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Customer Choice in Physiotherapy

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We live in an era of gradual patient empowerment, with increased patient choice, information sharing and transparency in health care as crucial drivers.
When customers are free to choose between providers, and information on services and quality are transparently available, competition will increase. This competition is believed to create a strong incentive for increased focus on quality. This means that, aside from the benefits for the customers, patient choice is a tool to reach a more qualitative, accessible, timely, safe and efficient health care system.

The dynamic of competition is still rather poorly understood in government-funded health care systems, such as in Finland. At this moment, very little research has happened on patient choice and information content needed to enable choice between providers.
The Social Insurance Institution (Kela) is offering freedom of choice between outpatient physiotherapy services for severely disabled people. However, the current information system is too limited and does not allow an informed choice.

A questionnaire was used to gain understanding of how severely disabled people and the people helping them in their daily decisions value freedom of choice between physiotherapy service providers and what kind of information they need to make this choice.
Severely disabled people and the people helping them with their decisions value the freedom of choice but are not satisfied with the information currently available on each option. One fourth of the customers look for information online, but are less satisfied with this information than customers asking health care professionals.
Information on accessibility and quality of care are the most important aspects this patient group is looking for, combined with reviews from other customers.

Through benchmarking current Finnish information tools with tools operational in the United Kingdom and the Netherlands, knowledge was gathered on how information tools are created and designed. This study provides evidence that information tools must be co-created by customers, providers and policy-makers. Once an information tool is operational, constant feedback and measurement of decision-quality is needed to improve the process. However, more research is needed to study the specific needs of different patient groups in Finland and more research is needed to gain a deeper understanding of how customers use comparative information in the decision-making process.

Keywords	Customer-centric health care, patient choice, information, physiotherapy, rehabilitation, online tool, informed decision.

Contents

1 Introduction

Imagine a situation many of us go through in our lives. You have just graduated from high school. The future is wide open and choices must be made. What to study? You will consider your interests, strengths and weaknesses, you will consider your dreams for the future. And you will consider where to study. What university suits your values best? Who offers what you need to fulfil your professional dreams? At important moments in life, people stop and think, consider and finally choose the best option. However, when it comes to who we will entrust with our health, we seem to give up this control. We let professionals decide about treatments and about who will provide this treatment. But there is change in the air. Trends such as client-centric health care, self-management, quantified self and the idea of expert patients are becoming stronger and mark the beginning of a new era in how health care is organized and consumed.

Patients are becoming health care consumers, claiming a voice in decision-making. Healthcare professionals and political decision makers are gradually reforming how health care is provided and are gradually empowering the patient. We are moving towards a patient-centric model.

Also in Finland there is change in the air. First legal and practical steps have been taken to enforce the status of the Finnish patient. However, at this moment, very little research and literature can be found on customer choice between health care service providers and the information infrastructure needed to enable this choice. This is the gap this study aims to fill.

Because a customer-centric health care is at the heart of matters, this study will focus on the customers and their opinions, needs and values.

1.1 Thesis background

Over the last decades there has been a shift in the role of patients within health care. People used to be passive recipients of health care services, with professionals making the decisions about who, what, where and when health care will be provided.

This approach has been replaced by the ideal of shared decision-making, increased patient involvement and choice (Edwards & Elwyn, 2009; Charles, Gafni, Whelan, 1997). There is no single explanation to this shift, but more a combination of changes and circumstances, affecting health care customers, health care professionals and decision makers. Figure 1 presents the process of this interaction.

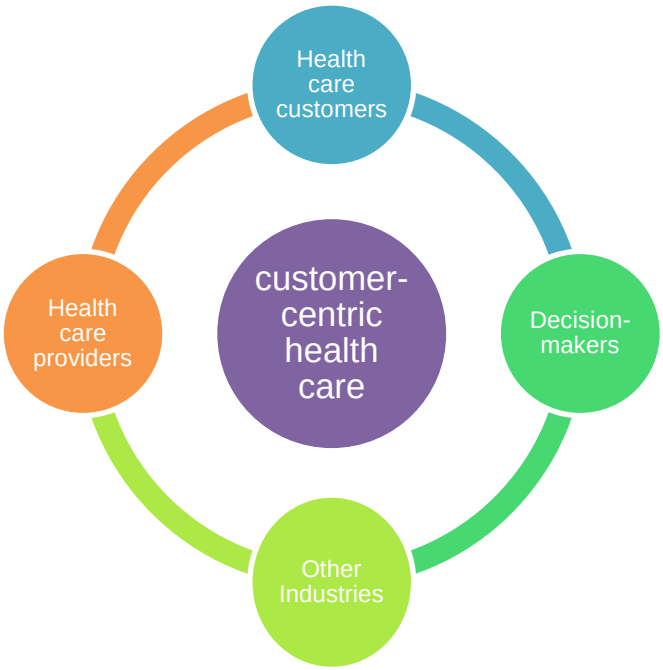

Figure 1: Interaction between different drivers towards customer-centric health care.

From the customer perspective, people are becoming more autonomous and take more responsibility for their own health and health care (Edwards & Elwyn, 2009). Coulter and Magee (2003) conclude in their research on the European patient of the future, that people increasingly demand to be treated like informed consumers, they demand more health care information and greater opportunities for involvement and choice. This trend is partly explained by an increasing ease to find health related information through media such as the internet. In developed countries this trend is also increasingly promoted by governments and implemented through health care reforms. A major driver behind these reforms is the modern view on humanity, where self-determination and autonomy are key elements (Faber, Bosch, Wollersheim, Leatherman and Groll. 2009). Another major driver is the belief that preventive, user-driven health care is economically more viable. Governments are pushed towards finding new ways to organize health care by rising expenditure on health care and financial austerity. This expenditure is predicted to continue to rise over the next years, with the ageing of the population in the western world.

Health economics see applications of the global trend of customer-centric models as a way to make health care more effective and efficient (Le Grand, 2007). Worldwide, the most profitable companies are companies that listen to their customers actively, companies in which value is co-created with the customer. When you buy a phone, you can add apps specifically adjusted to your needs and personal style.

When you buy a pair of running shoes, they can be adjusted to your body structure and personal style. People start to demand a similar voice when it comes to their health. Coulter and Magee (2003) stated that people want their wishes and preferences to be taken into consideration when deciding on treatments. They also concluded that people want more opportunities to choose among health care providers and more information to facilitate this.

It is this continuous interaction between health care providers, consumers and decision makers that lays at the basis of the shift towards a customer-centric model.

Charles, Gafni and Whelan (1997) cite that the key features of shared decision-making are

> ´the active involvement of both the patient and the physician, a sharing of information by both parties, both parties taking steps to reach an agreement about which treatment to implement'.

It is the ‘sharing of information’ that is at the core of this study. What kind of information is needed to make an informed choice between service providers? How shall this information be presented and delivered?

The word ‘information’ seems to hold a central role when searching literature on patient choice. The Directive on patients’ rights in cross-border health care adopted by the European Parliament and Council in February 2010, holds very clear guidelines (cited in Delnoij & Sauter, 2011):

> Article 4 (2) b states that health-care providers shall provide ‘relevant information’ to help patients make ‘an informed choice on treatment options, on the availability, quality and safety of the health care they provide in the Member State of treatment, clear invoices and clear information on prices’, as well as in relation to the status of the health-care provider and information pertinent to liability.

This Directive has forced all EU member states to increase efforts in measuring and publicizing quality of care indicators relevant for consumer choice (Delnoij & Sauter, 2011). However, questions are raised about what ‘relevant information’ is and who is to decide about that? Do health care professionals define relevant information similarly as customers do?

This study will benchmark available information tools in Finland and elsewhere in Europe. Additionally, this study will focus on what the Finnish health care customers find ‘relevant information’.

1.2 Problem statement

Freedom of choice between health care service providers is a rather new concept for most northwest European countries, such as the UK, the Netherlands and Scandinavian countries (Victoor, Friele, Delnoij, Rademakers, 2012). Finland finally joined the shift towards a more client-centric health care in 2010 with the passing of the new Health Care Act (Finnish Ministry of Social Affairs and Health, 2010). The main goal of the Health Care Act is the improvement of quality and safety of health care services, and enforcing the status of the client. Offering clients more freedom of choice and making health care more transparent were acknowledged as the tools to reach this goal. However, information on health care service providers in Finland is still difficult to find. There is no fully functional information tool that gives systematic, reliable information on health care service providers and no literature can be found on the opinion of the Finnish population on patient choice and information sharing. In a scoping review on patient choice research Victoor, Delnoii, Friele and Rademakers (2012) stated that most research has been implemented in the United States, the Netherlands and the UK. Finland was listed among those countries where the topic of patient choice was less researched. We can conclude that there is a clear gap in research and knowledge in Finland. This study is a step in filling this gap.

The subject of this study was developed together with the research department of the Finnish Social Insurance Institution (Kansaneläkelaitos - Kela). For severely disabled patients receiving rehabilitation services through social insurance (Kela) there is already the possibility of choice. Kela offers a range of different services and providers through their webpages, among which patients or their carers can choose. However, the information needed to make this choice is very basic and rather limited.

The first part of this study is focused on the current situation in information-sharing in health care in Finland and abroad. Specific focus is on information about physiotherapy service providers and includes a benchmarking exercise on content, structure and creation of operational information tools in Finland and abroad.

The second part of this study is focused on what information severely disabled Finnish people and their carers value, want and need in order to be able to make a choice among outpatient physiotherapy service providers.

The research questions are stated below:

1. How do severely disabled people value patient choice?
2. What kind of information is needed to enable informed choice among physiotherapy service providers?
3. What are important aspects in the creation of an information tool that enables choice between physiotherapy service providers?

2 Choice theories

The rational choice theory claims that 'all human action is fundamentally 'rational' in character and people calculate the likely costs and benefits of any action before deciding what to do' (Scott, 2000). People have preferences and will, when informed adequately, choose according to those (Levin & Milgrom 2004; Boyce, Dixon, Fasolo, Reutskaja 2010). However, evidence has shown that real-world choices are influenced by many factors and are strongly context-dependent. Levin and Milgrom (2004) list the following factors that may influence choice: the way in which a choice is posed, the social context of the decision, the emotional state of the decision-maker, the addition of seemingly extraneous items to the choice set, and a host of other environmental factors. It seems people often make choices based on intuition, not on reason (Levin et al. 2004; Boyce et al 2010). In familiar situations choices made based on intuition will often maximize preferences, but not when intuition is followed in unfamiliar circumstances (Levin et al. 2004).

In their book on social psychology, Smith and Mackie (2007), describe three processing principles for cognitive processes: conservatism, accessibility and superficiality versus depth. Mainly the last two principles are important in the search to understand decision-making processes. Accessibility means that the most accessible information, which means easily noticed and interpreted information, has the most impact. This is an important principle to remember when creating an information tool that is supposed to help people in their choices. How the information is presented, what information is presented and how it is presented are all important matters to keep in mind.

The second principle is that people can process information superficially or in depth. Smith and Mackie state that people usually process information superficially, and need strong motivation to stop and think more deeply. Kahneman describes this principle in depth in his book ‘Thinking, Fast and slow’ (2011), in which he challenges the rational model of decision-making. Kahneman describes two systems of thinking: one system is fast, intuitive and emotional and the second system is slower and more deliberative and logical. When comparing information and making decisions, the second system is most active. However, this slow, logical system is also biased and far less rational than the rational choice theory claims.

These are important aspects to keep in mind when reading on choice in health care and when thinking of how people will deal with information on health care providers. Examples of the dual system in decision-making can be found when reading on how health care customers deal with information on service providers. Faber and colleagues (2009) found that patients base their choice more on trust and intuition than on objective quality indicators. Only when they were not satisfied or unexpectedly forced to choose a health care provider, would people take more time in the decision-making process and use the available information in depth.

Faber et al (2009) describe four stages of how customers deal with quality information on health care providers:

Stage 1: AWARENESS of the availability of quality information

Stage 2: KNOWLEDGE. The actual ability to interpret the quality information and fully understand the meaning

Stage 3: ATTITUDE. Beliefs regarding the quality information. The actual trust, appreciation, value and use of this information

Stage 4: BEHAVIOR. Selecting or switching a health care provider based on the first 3 stages.

In order for choice to be based on quality information, all four steps need to be fulfilled. These steps equally provide a helpful framework when thinking of the creation process of an information tool. For example, customers need to be aware of the existence of the tool. This means that efforts will have to be done to make customers aware of the existence and availability of the information and the tool.

Information needs to be presented in such a fashion that people can understand the information.

Additionally, research must be done to evaluate if people actually change their attitudes based on this information and whether they change their actions and choose according to their values.

In the UK research has been done by Boyce et al (2004) on how knowledge about the mental process of decision-making can be used in the creation of the decision-making aids. They claim that nudges can be used to help people in their decision-making. Thaler and Sunstein (2008) describe a nudge as 'any aspect of choice architecture that alters people's behaviour in a predictable way without forbidding any options'. While nudges are more likely used for steering people's decisions and choices in the advantage of the company, Boyce and colleagues say it can be used for the benefit of the customer as well, in helping them make choices more in dialogue with their values. The same idea has been researched and is used in the United States. In the US, Thaler and Sunstein (2008) have studied the use of nudges to improve decisions on health, wealth and happiness. One example of a well-known nudge is the text 'smoking kills' on cigarette boxes. People still have the freedom to choose whether to smoke or not, but they are nudged not to. Another example of a less obvious nudge is how foods are placed in a school cafeteria. Placing fruits and vegetables on the most visible places, and the less healthy options in less visible places, is nudging towards healthier eating habits. The choice is still possible, the less healthy foods are still on the buffet, but people are nudged to take the healthier options. How nudges can be used in the specific application of information tools on health care providers will be described in the creation process of NHS information tools.

3 Patient Choice

3.1 What is patient choice?

Le Grand (2007) states that, in its broadest form, patient choice means that "patients have the choice of the where (the provider), who (the professional), when (time of care), what (the form of treatment) and how (the access channel) of health care".
Boyce and colleagues (2010) talk about the empowerment of people to make informed choices about their own health.

3.2 Why patient choice?

In their research to the effects of shared decision-making in health care in the UK, O'Connor and colleagues (2007) concluded that informed patient choice leads to a more efficient therapeutic alliance between health professional and patient and to a more satisfied patient. In his research on how patient choice has affected the Swedish need-based consumption of primary care, Janlöv (2013) came to the same conclusion. People who make active choices in health care are more satisfied (Janlöv, 2013). It is believed that treatments are more effective when patients choose, understand and control their care (NHS Choices 2012). Kemper (2009) even claims that information is not just given ' about' somebody's care but that information is 'part' of somebody's care and that information is therapy. The motivation behind this thought is that information motivates people's self-management and health-behavior and that it works as a preventive measure. (Kemper, 2009). Sepucha, Fowler and Mulley (2004) state that variation in medical treatment choices and service provider choice are essential components of quality of health care, if this variation is based on patients' wants and needs.

However, the believed benefits for the patients, regardless how important they are, are not the only driver behind the efforts to stimulate a system of increased patient choice. Health care in the EU is facing many challenges. An increased consumption of health care and the ageing of the population are among the reasons that have given an extra boost to the efforts of finding different ways to make health care more efficient. In a recent press release from the European Commission, Nellie Kroes (2014), states that

> making the most of digital tech can help in reducing healthcare costs, putting patients in control, make healthcare more efficient and help European patients take an active part in society for longer .

In the Netherlands patient choice was introduced as part of the health care reform in 2006. Before the reform the Dutch health care system was centralized or state-oriented, with the government regulating the health care supply. Victoor et al (2012) explain how this kind of system leaves government, providers and patients acting independently from each other, with no incentives for responding to patients' needs, innovation or flexibility and no incentives to improve quality or efficacy. The ideal of the reform was to create a demand-driven health care with managed competition as one of the major drivers (Schäfer, Kroneman, Boerma, van den Berg, Westert, Devillé, van Ginneken, 2010).

Managed or regulated competition was intended to replace the governmental regulation of health care supply (Victoor et al, 2012) and enabling patient choice between health care providers and insurers was an instrument to reach this competition. Also in the UK, patient choice was introduced to increase competition in health care. The assumption behind this logic is that people will choose the best health care provider once they are informed (Le Grand, 2007)

In his book ´The Other Invisible Hand´, Julian Le Grand (2007) states that a good public service should have the following five basic attributes: high quality, efficiency, responsiveness, accountability and equity. Controlled competition is seen as the instrument to control costs in health care and reach more efficient, more responsive, more qualitative and more accessible health care (Le Grand J. 2007).

For several years the UK Government has been committed to increasing patient choice and publishing more information on the quality of health care services and providers (Boyce, Dixon, Fasolo, Reutskaja 2010). In 2009 the right to informed choice was taken into the NHS Constitution and started an 'information revolution' (Boyce et al, 2010).

Research done by Dixon, Robertson, Appleby, Burge, Devlin and Magee (2010) after the reform in the UK, revealed that competition did indirectly increase the focus on quality by providers. They state that sharing mainly patient feedback is a driving force behind quality improvement.

Research done after the introduction of the quasi-market and patient choice has also raised a word of caution. Janlöv (2013) found that health care customers with a higher income seem to be most satisfied with the introduction of freedom of choice. In their report, Boyce et al (2010) mention that patient choice and the use of online information tools may place certain patient groups in a disadvantage and in doing so, jeopardize the equal accessibility of health care. They point out that certain patient groups may be less willing to choose or less able to choose. Access to internet or diminished abilities to understand and interpret sometimes complicated information on health care quality are mentioned as two possible explanations. Different patient groups also have different needs for information.

Victoor et al (2012) have a critical word to the Dutch government in the aftermath of the health care reform of 2006 concerning this matter. The Dutch government had assumed that patient will automatically value the freedom of choice between health care service providers. But their research showed that not all patient groups are inclined or able to choose. They warn that it shouldn’t be assumed that people value choice.

It must be researched and the freedom of choice must be actively promoted, and maybe instruments need to be developed to encourage choice (Victoor et al, 2012)

In Finland a new Health Care Act came into force in 2011. This Health Care Act is based on the assumption that enforcing the clients of health care increases the quality of the care.

3.3 How does patient choice happen?

Patient choice can be a good incentive for increased focus on quality (Le Grand, 2007), but there are a few conditions that need to be fulfilled (Boyce, Dixon, Fasolo, Reutskaja. 2010). The main conditions are that there must be enough choice options, patients must be aware of these options and their rights, there should be a standardized method to measure the quality of each option and there should be an easy access to adequate and sufficient information on each option (Victoor, Friele, Delnoj, Rademakers 2012). Victoor and her colleagues (2012) explain how patient choice is interrelated to different aspects in order for it to lead to quality increase and cost containment in the Dutch health care system. Their data was used to create the graph in figure 2 and portray the relations between all aspects.

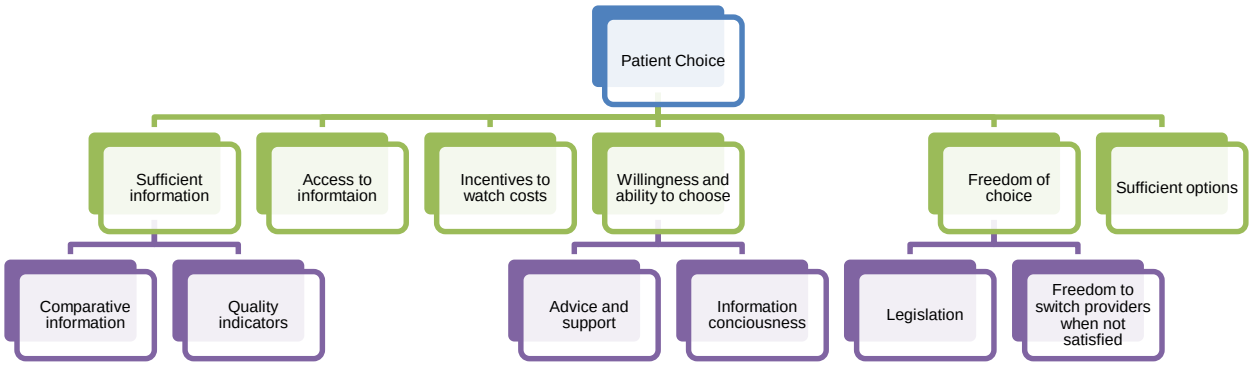

Figure 2: Interrelation of aspects leading to patient choice.

An important remark on the aspect of quality indicators is that this aspect assumes a standardized method to measure the quality of each option. Measuring quality in health care is a highly debated and complicated matter.

As will be explained later in this report, the health care reform in Finland aims to give patients gradually more freedom. It is described in detail when and how this freedom will be extended. Part of the plan is to make the medical information of people more easily accessible on each point of care delivery. At this moment, there is no mention of increasing information on health care service providers. This is unfortunate, because in the light of this literature study, information sharing and increasing transparency are central to a health care system where patients have the freedom to choose.

4 Information tools

Elwyn, O'Connor, Frosch, Volk and Feldman-Stewart (2009) describe an information tool or decision aid as a form of decision support technology.

> They are tools which are designed to support individuals in making decisions about situations where at least two reasonable options exist and where high-quality information needs to be presented, preferably in understandable formats.

The International Patient Decision Aid Standards (IPDAS) Collaboration states that the aim of patient decision aids is to improve the quality of decisions. A qualitative decision being an informed, values-based decision. “Decision quality is the extent to which patients choose and/or receive health care interventions that are congruent with their informed and considered values.” (IPDAS, 2014) Research has shown that decision aids help patients make choices that are consistent with their values (O'Connor et al 2007).

Other terms for these aids are found in literature, such as decision support tools or information tools. It is important to mention that there are significant differences between different kinds of decision-aids. When searching literature using the term ‘decision-aid’, one will mainly find information on tools that are created to help patients when having a choice between medical treatments. The focus of this study is on information tools so that customers can choose between different service providers. To make this difference clear, the term information tool will be used.

5 Patient choice and information tools in Finland

An important step in strengthening the customers' position in health care and increasing freedom of choice in Finland was the Health Care Act coming into force May 1st 2011. This Health Care Act was the first step in the total reform of social and health care organization in Finland. The specific aim of this act was the strengthening of the status of the client and improvement of the quality and safety of care. Increasing the freedom to choose the place of care and guaranteeing equal access to care were the tools to reach this aim (Finnish Ministry of Social Affairs and Health, 2010). The Health Care Act came into force in 2 steps. The first step became effective on May 1st 2011 and enabled patients to choose the place of care and the health care professional within his or her municipality or cooperation area.

In dialogue with the referring physician or dentist, patients can also choose the place of specialised medical care in a wider area. In a second step, in force since January 1st 2014, clients are allowed to choose a health care centre or unit for specialised medical care in the whole of Finland (Finnish Ministry of Social Affairs and Health, 2010).

With the new Health Care Act several initiatives started off to support the increasing freedom of choice, the strengthening of the clients' status and create more opportunities for self-management. The National Institute for Health and Welfare (THL) launched Palveluvaaka on March 7th 2011. This is an information tool aimed at sharing information about social and health care service providers for health care clients. Another example of an initiative to enforce the status of the customer is the active involvement of Sitra in introducing the concept of the Health Kiosks and promoting self-care. So decision-makers and Finnish health care think-tanks are all working towards a stronger position of the patient within the Finnish health care.

5.1 Organization of health care

Finland's health care system is founded on government-subsidized municipal social welfare and health care services. In addition to the public sector, private and non-governmental organizations provide health care services (Teperi, Porter, Vuorenkoski, Baron 2009). Figure 3 presents graphically the organization, funding, provision and supervision of health care in Finland.

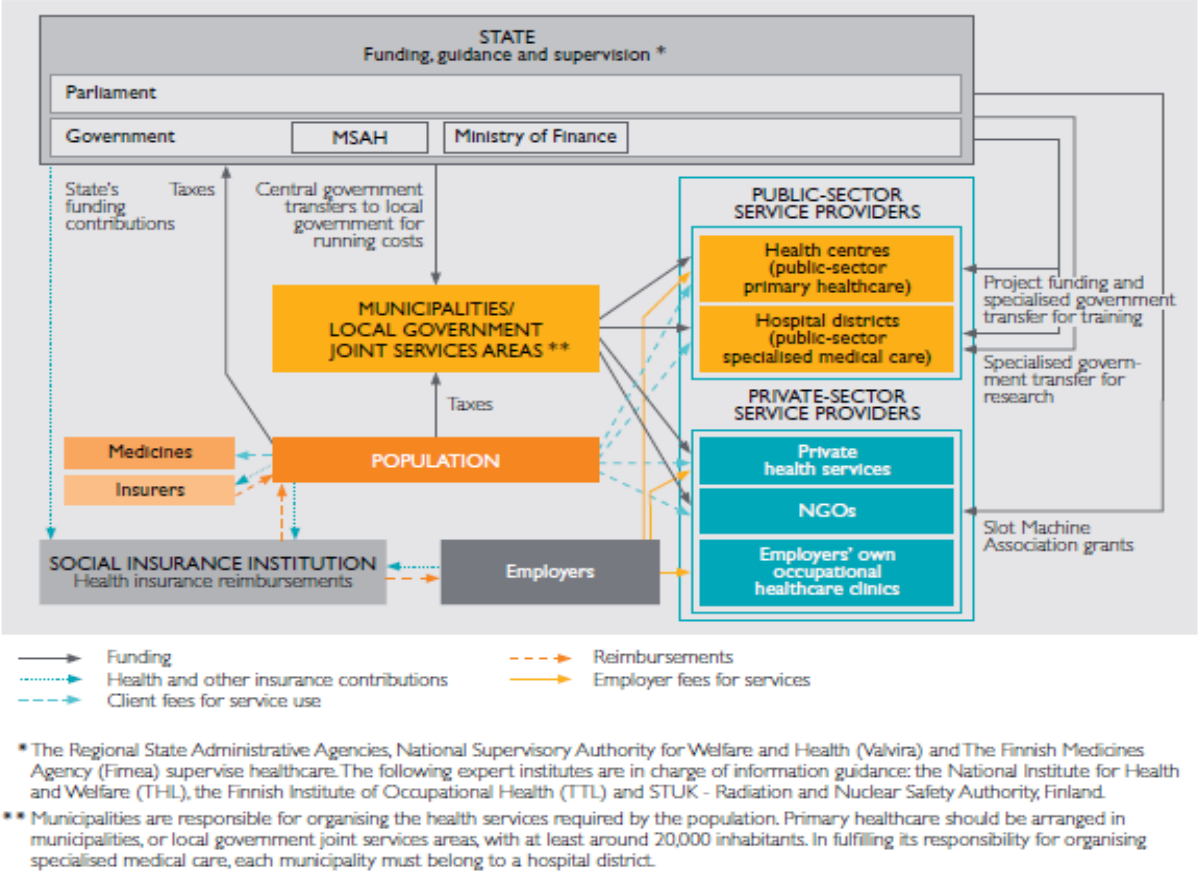

Figure 3: Organisation, funding, provision and supervision of health care in Finland. Source: Ministry of Social Affairs and Health, Finland.

Statutory Health Insurance covers the whole population and is divided into medical care insurance and earned income insurance. The Social Insurance Institution (Kela) coordinates Health Insurance.

Medical care insurance reimburses for tests and treatments ordered by private doctors and for client charges according to the statutory reimbursement rates. Medical care insurance is deducted from the income, pension and benefits from all policy-stakeholders. Earned income insurance covers mainly sickness allowance, rehabilitation allowance, special care allowance and maternity, paternity, parental and special maternity allowance.

Clients can be charged for municipal health care services. These client charges are laid down by laws and decrees and are revised every other year. A ceiling is set on client charges in public health care and certain services will be offered free of charge or at a reduced rate once this ceiling is reached.

Private health care providers, among which physiotherapy providers, can sell their services to local authorities, joint municipal authorities or immediately to the clients.

Health Insurance reimburses patients for some of private doctors' and dentists' charges. Clients can purchase private insurance for private health care services.

Health centers and hospitals provide medical rehabilitation and physiotherapy as part of medical care. In addition to these service providers, rehabilitation and physiotherapy is also available through organizations such as the Social Insurance Institution of Finland (Kela), authorized pension providers and employment and education administration. Physiotherapy services are also offered immediately to the clients. In this case, reimbursement is only possible with a doctor's referral.

Kela organizes medical rehabilitation and reimburses the costs of rehabilitation for people under the age of 65 suffering from a severe disability. Rehabilitation services are provided by rehabilitation centers or outpatient clinics, who have obtained a contract with Kela through public procurement. This study focuses mainly on severely disabled people receiving outpatient rehabilitation services through Kela. At the moment this patient group can choose among 1235 service providers nationwide (September 2014, source: https://easiointi.kela.fi/ePTKHaku/).
In 2013 approximately 14 500 severely disabled persons were receiving outpatient physiotherapy services through Kela, with a total expenditure of 62 million Euro (Kelasto 2013). The aim of this service is to restore or increase quality of life, independence and employment possibilities of this patient group.

5.2 Available information tools

Easiointi.kela

The rehabilitation pages of Kela contain a search engine, easiointi.kela.fi/ePTKHaku, which enables customers to look for basic information on the different providers of physiotherapy services for severely disabled persons. Figure 4 shows a screenshot of the search start of this tool.

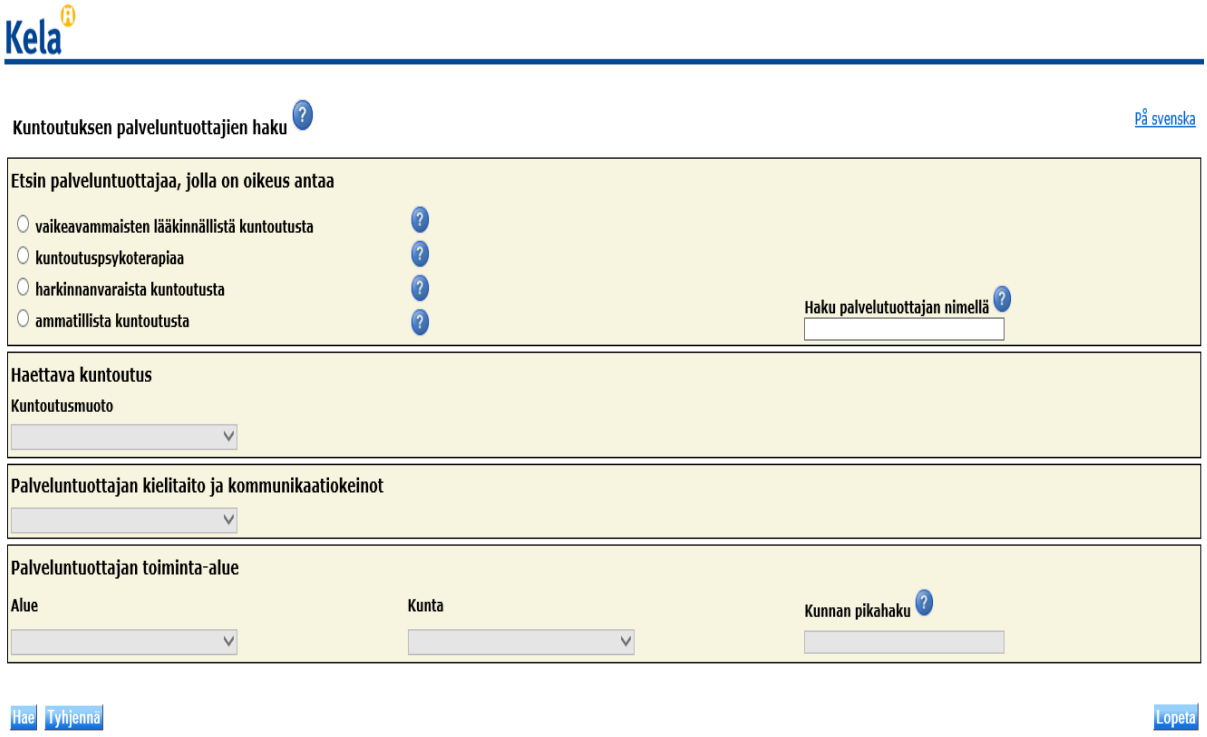

Figure 4. Screenshot of search start through easiointi.kela.fi/ePTKHaku.

This search results in an alphabetical list of providers, including address, phone number, email addresses and a link to the providers' own web pages, if available. Appendix 2 shows the screenshot for the website presenting the listing from easiointi.kela.fi/ePTKHaku.
This is a very basic tool, providing only the most practical information.

No other online information system that could help in the decision process between physiotherapy service providers is operational in Finland. Openly available, easily comparable, transparent information is not the standard yet. The bigger physiotherapy service providers have own web pages and people can visit each of those to collect information, but many providers have no or poorly updated pages.

Palveluvaaka.fi

Palveluvaaka.fi is a relatively recent initiative from The National Institute for Health and Welfare (THL) to increase transparency of social and health care service providers in the process of the Finnish health care reform. The first draft was opened for public on March 7th 2011.

The purpose of this project is to create a platform which customers can use in their search for information on social or health care services and service providers. The site also gives customers the opportunity to compare service providers and give feedback (Palveluvaaka, 2014). At this moment information available through Palveluvaaka is limited and only applies for certain services: health care centers, hospitals and elderly care.

Information currently available:

- Comparable information on waiting times in health care stations and hospitals
- Client satisfaction information from 4 hospital districts and 13 health care centers
- Information on a limited amount of services (physiotherapy not included) for elderly from 150 service providers

No information is available through this channel to help patients in their decision process between rehabilitation providers. The site is currently being updated and will be launched again in 2015.

Figure 5 shows the starting page when searching through Palveluvaaka.fi.

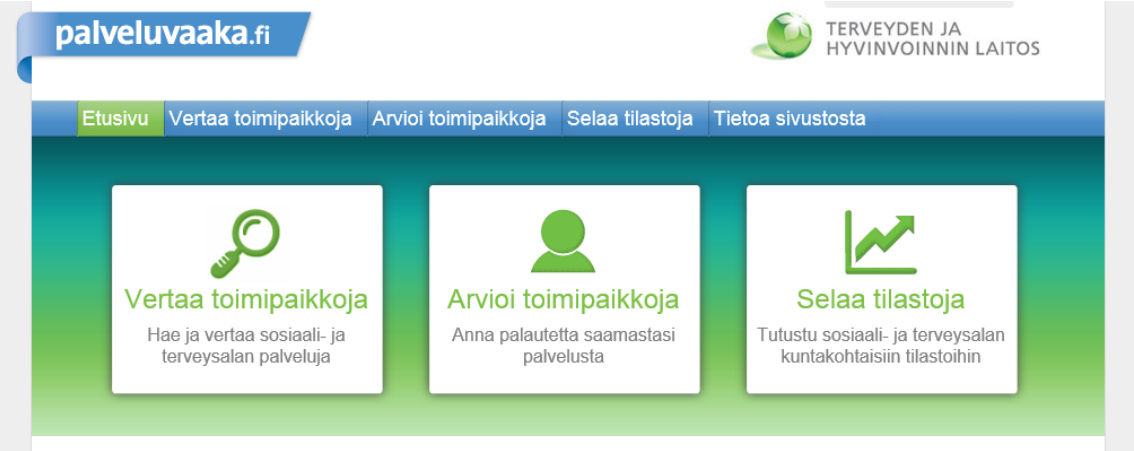

Figure 5. Screenshot of search start through Palveluvaaka.fi

Appendix 3 shows screenshots of following pages and results when continuing the search through Palveluvaaka.

In the renewed Palveluvaaka.fi, following aspects will be included:

- General information of the service provider
- Listing of provided services
- Information on accessibility
- Information on service content

Customers will be able to compare service providers based on various quality parameters and customer feedback.

The creators of Palveluvaaka.fi mention explicitly the importance of this tool for both customer and provider. For providers it creates a tool for marketing own services and gaining more visibility. Providers will be able to manage certain parts of their scorecards. Customer feedback gives great opportunities for improving quality and developing towards an increased patient-centric approach. For customers it increases the freedom of choice and the possibility to reach clear and reliable information on which a choice can be based. For institutions involved in health care organization and financing it creates a clear overview of available and missing information, it brings out problem areas and gives the opportunity to tackle these. It is also seen as a tool to increase patient safety and to accelerate the creation of services. (National Institute for Health and Welfare, 2014)

The creation of Palveluvaaka

Palveluvaaka was created and is kept up-to-date by THL. All health care stations of mainland Finland are sent a yearly questionnaire covering all aspects of the care guarantee. THL states that the response rate is 90-98 % and provides all information on waiting times and other aspects of care accessibility.

Information on waiting times and care accessibility from specialized medical care units is collected 3 times a year. Providers of specialized medical care are legally obliged to provide this information on set times (30.4, 31.8 and 31.12).

Client satisfaction questionnaires are created by THL and distributed through the service providers. Clients are also able to be in direct contact with Palveluvaaka.fi.

Information on care effectiveness and efficiency are obtained through the PERFECT Project (PERFormance, Effectiveness and Cost of Treatment) from THL.

Information on providers of elderly care is obtained from those providers that use the RAI-development system and have given permission of publishing the results through Palveluvaaka.

In an email conversation a project manager of Palveluvaaka-THL mentions that customers are involved in the process by giving feedback on providers. This feedback can be given about dental and maternity care on the moment, and will be expanded gradually.

The creators of Palveluvaaka encounter challenges in their quest to maintain and expand the scope of Palveluvaaka.

The first challenge being the limited amount of available information on the different providers and services and, if information is available, it is not always reliable and up-to-date. Another challenge is the importance for information to come from an independent and reliable source (National Institute for Health and Welfare, 2014).

6 Patient choice and information tools elsewhere in Europe

Many countries in Europe have already a long-established system of freedom of choice among health care service providers. This does not always go hand in hand with transparency and sufficient informative tools on services and quality. As was mentioned before, freedom of choice has not been part of the health care systems in countries like the UK, the Netherlands and most Nordic countries, such as Finland. However, in the UK and in the Netherlands major reforms have happened during the last decade and major efforts are done to enforce the position of the patient as consumer. These countries also have state-funded health care systems, such as Finland.

For these reasons information obtained from research in the UK and the Netherlands is more applicable in Finland than research done in countries such as the United States. On these grounds it was decided to focus on the Netherlands and the UK.

This part of the study was started from the perspective of the customer. Through an internet search available information tools on physiotherapy service providers were selected. Specific focus of this benchmarking exercise went to the structure and creation process of each information tool.

First there will be a short introduction of the organization and financing of health care provision in each country and the organization of physiotherapy services. After this an introduction of available information tools on physiotherapy service providers and a report of the creation process of each tool.

6.1 United Kingdom

6.1.1 Organization of health care

The United Kingdom has a rather complicated system of health care provision and financing, so a simplified version will be described. In the United Kingdom there is a system of public and private healthcare.

Public health care is mainly free at the point of use for everybody residing permanently in the country and is paid for through general taxation. People can also buy themselves services from private health care providers, or buy extra health care insurance through private insurers. (Boyle 2011; Wikipedia)

The United Kingdom is divided in countries: England, Northern Ireland, Scotland and Wales. And health care systems are slightly different in each country. (Boyle 2011, Wikipedia) In this report focus will be on England, because the main interest goes towards the National Health Service (NHS) in England and their efforts in promoting patient choice. The NHS provides preventive, primary and hospital care. See figure 6 for a full view of the organizational system for public healthcare in England. (NHS – Guide to the Healthcare system in England, 2013).

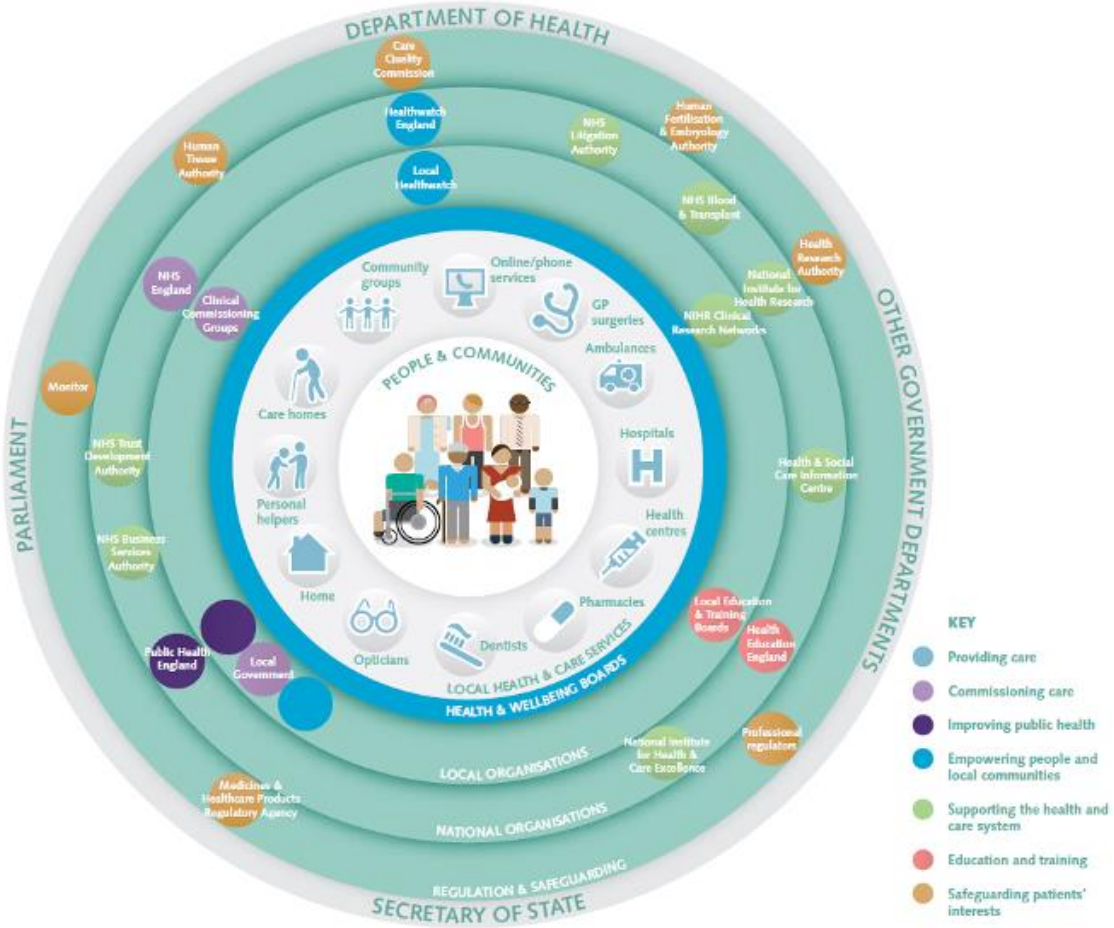

Figure 6. Healthcare system in England from April 2013. Source: NHS

Over the last decade, health policy in the English NHS has developed in three overlapping phases (Dixon et al, 2010). In the light of this research, the most interesting phase was the third phase, which had the following key areas:

1. new financial mechanisms such as the prospective, activity-based fixed price reimbursement system (Payment by Results);
2. greater devolution and independence from central control (foundation trust status);
3. encouragement for a more pluralistic mix of public and private provision of NHS care;
4. an emphasis on competitive quasi-market forces between providers; and
5. more formalised provision of choice of hospital for patients.

When focusing on physiotherapy provision, there are different ways to receive physiotherapy services: through the NHS, through private practitioners or through occupational health schemes. Through the NHS, the General Practitioner (GP) will help with the referral to an NHS physiotherapist. In this case physiotherapy is free of charge. In some areas in England patients don't need a referral from the GP, but can book a time with a NHS physiotherapist directly (Chartered Society of Physiotherapy).

Self-referral has been popular for people with chronic conditions, who know what treatments they require. The listed benefits for self-referral are the time saved for both GP and patient, the shortened waiting times, the improved attendance levels at appointments and the empowering of patients to manage their health. (NHS Choice. Physiotherapy)

People can buy physiotherapy services also privately or through their private health insurance. There are online tools available for choosing a private practitioner, for example www.physio2u.org.uk and www.physiofirst.org.uk.

Detailed contracts are made with providers of rehabilitation services for severely disabled persons. One aspect of this contract covers all service user and care information. Providers are obliged to provide a list of information about provided services, benefits, relevant helplines and publications using multiple means, such as oral, written and online. Patient and public engagement is stated as very important in order for the rehabilitation to be most effective. Patient and family/carers are seen as an important part of the multidisciplinary rehabilitation team (NHS-Standard contract. 2014).

6.1.2 Available information tools

Three information tools are operational in the UK for people searching information on physiotherapy service providers: the choose-and-book tool from the NHS, Physio2u created by the Chartered Society of Physiotherapy (CSP) and Physiofirst created by a membership organization for physiotherapists in private practice in the UK.

http://www.chooseandbook.nhs.uk/

The NHS claims to place customers at the heart of their operations and informed patient choice is an important part of their policy. All through the website of the NHS following logo can be found:

Figure 7: NHS choice logo

The webpages of the NHS (www.nhs.uk) do not provide a listing of all NHS physiotherapists but through their choose-and-book system a list of hospitals and additional information is represented when entering ‘physiotherapy’ or ‘rehabilitation’.

As figure 8 demonstrates customers can choose the place, time and date of appointment (also physiotherapy services) and manage own appointments online once they have a referral number from their doctor. To choose the hospital, there are links to the website for NHS Choices.

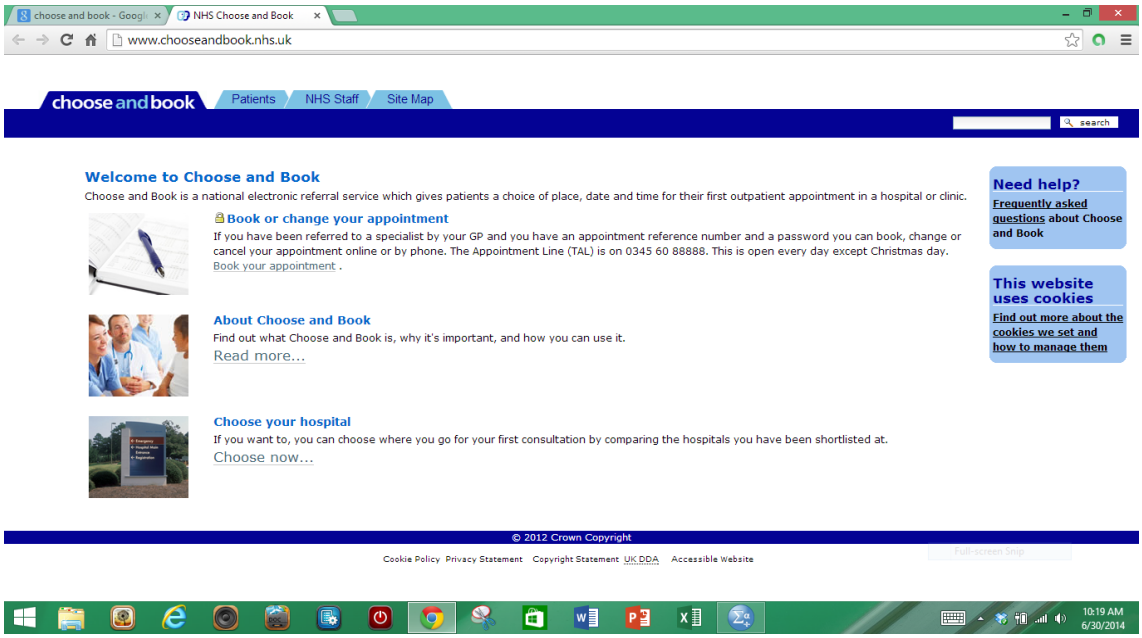

Figure 8. Choose and book starting page.

The choice option of ‘choose and book’ redirects to the NHS Choices webpage (figure 9).

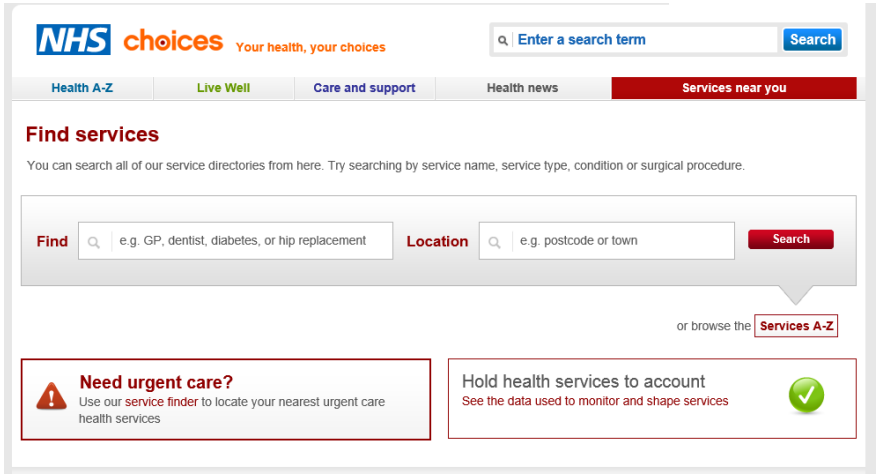

Figure 9. NHS Choices starting page

A search for physiotherapy or rehabilitation services starts through ‘services near you’, through which a diagnosis or service relevant to the choice can be entered (in this example: physiotherapy or rehabilitation) and a location (postcode or town). This results in a list of relevant service providers. The following information is provided for each service provider:

- Name of institution

- General information (address, phone number)
- Distance and directions from entered location
- Symbols on specific, practical information, such as parking possibility, wheel-chair accessibility, hearing induction loop availability etc.
- Information on the fact if the hospital has met the Care Quality Commission National Standards
- Percentage of staff that would recommend the hospital
- Information on hospital's responsiveness to patient safety alerts

When opening the full scorecard of a service provider, an application is started with following sections: overview, departments, facilities, contact details, map, directions and reviews and ratings and leave a review. This is a list of the provided information:

- Overview with introduction text, map and directions and reviews of the provider
- List of departments, who provides the services and reviews of each specific department
- Facilities: information on accessibility, accommodation, faith services, food, amenities on-site and parking. Patient comments on these facilities are added.
- Map and specific, detailed information on location, directions and travel information.
- Ratings and reviews. Overall customer experience rating, using a star system, with 5 stars being the maximum. Further ratings of cleanliness, staff-cooperation, dignity and respect, involvement in decisions and same-sex accommodation. All using the same star-rating system. Full list of all patient reviews.

Appendix 4 gives screenshots of the search results. The overview gives a lot of information on one screen. People can keep following links to receive more information on aspects that interest them.

Another specific tool for physiotherapy service providers is the website **www.physio2u.org.uk.**

Physio2u is a tool created by the Chartered Society of Physiotherapy (CSP), the professional, educational and trade union body for chartered physiotherapists and physiotherapy students in the UK.

A search starts with entering postal code and specific diagnosis or treatment specialization. Figure 10 shows the starting page for Physio2u.

Figure 10. Starting page Physio2u.

After submitting these requests, a list with following information is presented (appendix 5):

- Name provider
- Address
- Opening hours
- Distance to entered location
- Payment options (private or NHS referral)

The full scorecard on any of the listed providers can be selected and opened. Screenshots are collected in appendix 5. Following information is included:

- Detailed address and location
- Map
- Link through which practice can be contacted
- Link to own webpage
- Short introduction text
- Opening hours
- Specialties
- Payment options

A non-sponsored practice has a very similarly looking scorecard, but results are listed towards the end and there is no link to own webpage.

http://www.physiofirst.org.uk/

Physiofirst is a membership organization for physiotherapists in private practice in the UK.

Search starts from a list of criteria, from which the customer can choose one or more, as figure11 presents.

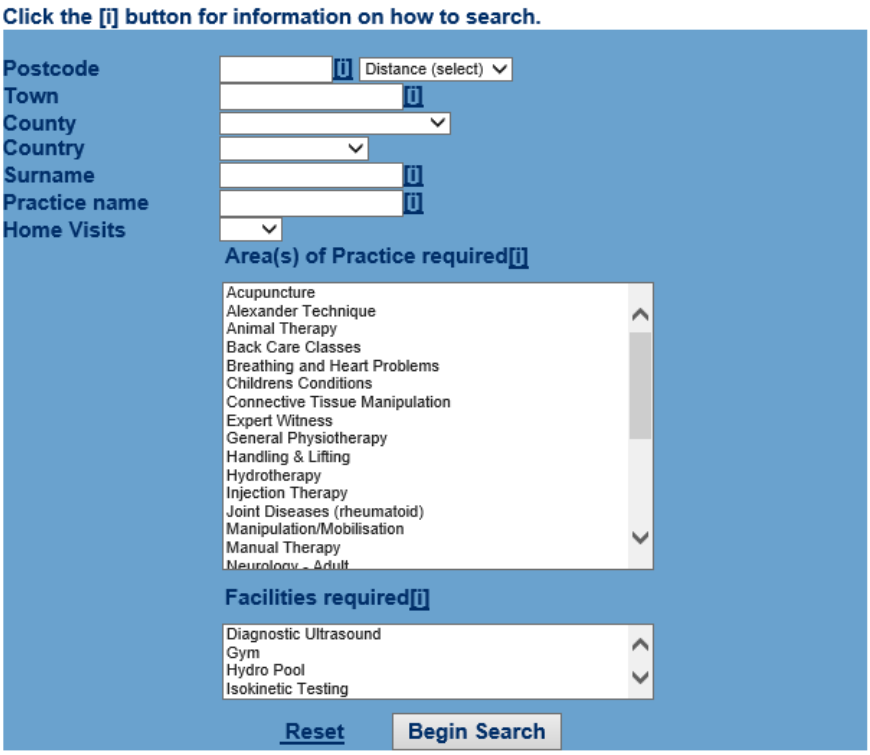

Figure 11: Search start through Physiofirst.

Criteria include:

- Postcode
- Town
- County
- Country
- Surname
- Practice Name

- Information on home visit possibility
- Areas of practice
- Facilities

This search results in a list of physiotherapists, the department or practice they work in and address of the practice (appendix 6). A scorecard can be opened on each provider, which offers information on all of the above criteria and adds a link to own webpage and possibly includes an email address.

This tool is very limited and provides only the most basic information. For this reason the creation of this webpage was not studied any further.

6.1.3 Creation process of the information tools

Creation of NHS Choices webpage

Through an email conversation with people from the NHS Choices Data Team, it was possible to receive the report on which the structure and creation of the choice tool was based. This report gives the results of research done by Boyce, Dixon, Fasolo and Reutskaja on the role of nudges, scorecard design and information in the choosing process of a high-quality hospital (The King's Fund, 2010).

This is an interesting report, as it gives evidence-based information on scorecard design and information content in the decision process among health care service providers, be it specifically hospitals. Interesting aspects can be transferred to similar tools for physiotherapy service providers.

Boyce et al. (2010) aimed to answer the following questions:

- What information do patients use when choosing a hospital?
- What is important to patients when choosing a hospital?
- How does the design of information influence the choices that patients make, and in particular, how do nudges affect people's decisions?
- Do people make better choices as they become more practiced in making decisions?

As for nudges, they tested three different types:

- Pre-select (default) nudges: preselect the hospital of highest quality in terms of clinical effectiveness and quality of care.
- Preference nudges: provide tools that help people understand their own preferences and values better.
- Feedback nudges: offer feedback to people who based their choice on non-clinical indicators and offer the opportunity to reconsider the choice

. The following conclusions were made on information content and organization:

- Use clear labels for indicators so that they can be easily understood without having to click through to further information
- Use symbols and labels consistently
- Order quality indicators so that the most important are listed first
- Where possible, make the data relevant to the procedure the patient is having
- Do not include summative measures
- Group indicators into domains
- Apply evaluative labels (for example: ‘poor’, ’good’, ‘excellent’)

Boyce and colleagues came to following conclusions in their specific research on the use of nudges:

- People spent most time looking at information presented first. Placing quality indicators at the top of the scorecard nudges people to pay more attention to these.
- When placing comparative information on providers beside each other, people spent most time looking at the first column, so first provider, and not on looking at the rows. So people were not spending a lot of time comparing providers.
- When people were first asked to consider what was most important to them, they acquired and used information more systematically.
- Feedback nudges and preference nudges prompted people to make a more mindful search of information and to place more focus on quality indicators.

Regardless of age and education, people made better choices (=more in line with their values and preferences) when having the chance to ‘practice’.

What kind of information, how much information and how to organize this information are all important aspects to consider when creating an information tool. Another aspect to consider is the specific target group. Boyce et al concluded that different patient groups have different needs of information and react differently to the presentation.

Creation of physio2u

There is a major difference between ‘choose and book’ and physio2u. Physio2u is a commercial tool, which is completely in the hands of the service providers themselves. There is no independent organization behind it, so there is no objective information on quality.

Service providers have full management rights to their own scorecards. If they are a member of the Chartered Society of Physiotherapists, they can list their practice for free. For extra visibility, a more extensive page and inclusion of a link to own webpage, service providers pay a premium of £49 a year.

6.2 The Netherlands

6.2.1 Organization of health care

Zorgverzekering Nederland was used as a source for the information on the Dutch health care organization. Everybody who lives or works in the Netherlands is obliged to have a basic health insurance. This insurance covers basic healthcare services, such as standard services by MD, standard hospital and pharmacy costs, after an own risk payment of 360€ (in 2014). This is decided upon by the Dutch Government and all insurance companies must offer a similar basic insurance for everybody at a similar price.

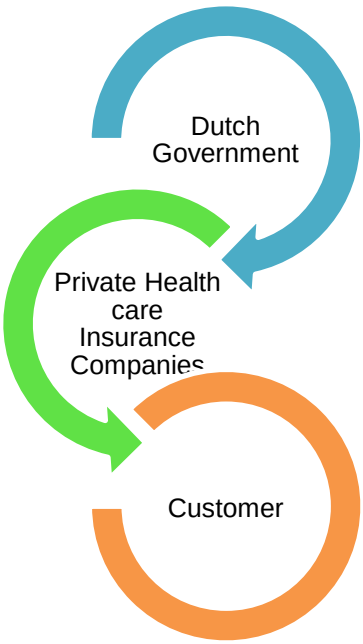

Figure 12: Basic Healthcare Insurance Process

Insurance companies are not allowed to charge extra for chronically ill people, elderly, etc. Neither are they allowed to refuse the basic insurance to any potential customer. The government has a budget for compensating the risk to the insurance companies. This is called risk equalization.

People older than 18 pay a set premium and an income-related percentage for this basic insurance package. With other words, people pay a set price for a set package of services. There is no free choice of content of this basic package. This way the cost for general healthcare is spread over all citizens and equal healthcare can be provided to everybody, regardless of age, gender, background, health condition etc.

Aside from this standard coverage, people can buy extra insurance, from the same or any other insurance company as the one providing their basic package. Insurance companies can refuse people for the extra insurance, and are allowed to question possible customers about their health before acceptance. Insurance companies have contracts with certain service providers. People are advised to inform themselves about these contracts so that they can be reimbursed for the treatment with their provider of choice.

Certain physiotherapy services are included in the basic insurance. These are the covered areas:

- Treatment and revalidation for certain conditions
- Help devices for use in revalidation of specific conditions
- The first 9 treatments for children and young people up to the age of 18
- All treatments for children and young people with certain chronic conditions
- Limited physiotherapy services for certain chronic conditions starting from the 21st treatment.
- Revalidation of pelvic floor muscles in case of urinary incontinence, up to 9 treatments.

In the Netherlands physiotherapy service providers are obliged to openly document their prices in their clinics. No referral is needed from a doctor to visit a physiotherapist, but diagnosis is important for treatments within the basic insurance package. Patients are advised to check what is the policy about physiotherapy services with his or her insurance company, for example the inclusion of different treatments, the level of reimbursement, a possible own starting fee etc. People also have to check whether their insurance company has a contract with the provider of choice.

Depending on the diagnosis, stage and severity of the disability, patients are entitled to revalidation in a revalidation center, revalidation department in a hospital, a revalidation home or with a specialized physiotherapist. This decision is made in dialogue with the revalidation specialist. Information tools are available to help people with their choice of provider.

6.2.2 Available information tools

There is a multitude of online information systems available for patients in the Netherlands. Some systems are initiatives from the Ministry of Health, others are private undertakings created to some extend in partnership with the Ministry. Health care insurers have their own systems so that their clients can choose the provider best suited for him or her. When searching the internet for information on physiotherapy providers, the multitude of tools is overwhelming.

A relatively big effort is needed to read small print on the organizations behind each tool and the sources of information. Compared to the information tools in the UK, there seem to be many commercial websites, created for monetary gain rather than the aim of helping people find the provider best suiting his or her needs. This aspect of information tools will be further discussed in the summary. A selection of systems is listed in the report below.

www.revalidatie.nl

The site www.revalidatie.nl is a very informative portal for people with a severe disability and the people helping them with their care and decisions. It holds multiple links to practical information on diverse topics. It also holds a search tool people can use when looking for a revalidation center.

As figure 13 demonstrates there are 4 ways people can start the search: by entering a postal code, town name, name of the revalidation center or by selecting a province on a map of the Netherlands.

Figure 13: search start through www.revalidatie.nl

The search results in a listing of centers (appendix 7), with following information:

- Address
- Telephone & fax
- Link for sending email
- Link to centers' own webpage

This listing is very basic, and requires people to visit each center's own webpage for more information.

Through another link on the site, information can be found on waiting times for specific revalidation centers (appendix 7). Each listed center comes with a link to the own webpage informing in detail about specific waiting times.

Even though this website is very informative on the organization and financing of rehabilitation for severely disabled people, it does not seem to be an excellent tool for increasing patient choice among service providers. Information is very basic and it requires visiting the webpages of each revalidation center. This is a very time-consuming activity and does not allow comparing the centers.

For this reason no information was collected on the creation process of this tool. Nevertheless it was decided to include this link in the report, because it was the only site specifically geared towards people with a severe disability.

www.kiesbeter.nl

This site is an initiative from the Dutch Ministry of Health. It is fully dedicated to providing information on quality of health care provider. The search starts by selecting what kind of service he/she is looking for: hospital, home care provider, care centers or maternity care. A postal code or town name can be added, including an estimation of the area around this location (expressed in km).

Figure 14: starting page for www.kiesbeter.nl

This search results in a list of providers with following information (appendix 8):

- Name institution
- Address
- Distance to preselected location

When selecting a service provider, a page opens with a drop-down box in which you can select a medical condition and a list of following information:

- Scores on quality indicators (using a 3-star system: one star = below average quality, two stars = average quality, three stars = above average)
- Extensive list of inspection scores by Health Care Inspection
- Name institution
- Address

- Link to own webpage

A definite disadvantage to the usability of this online tool, is the impossibility to preselect a specific diagnosis or service need. It is not possible to select a list of centers providing rehabilitation for severely disabled people. Instead it is necessary to scroll through the full list of hospitals and centers and open each provider's scorecard to find out what kind of services are provided. This site is more useful when the customer has already certain providers in mind and needs additional information on quality of services. This tool allows comparison of up to 3 providers.

www.zorgkaartnederland.nl

This online information tool is an initiative of the Dutch Federation for Patient Customers (Nederlandse Patienten Consumenten Federatie-NPCF).

The search starts from an extensive list of criteria, as figure 15 demonstrates. Patients can start by entering a certain provider or location or by selecting from a list of health care services, organizations or locations. Or customers can open a specific help tool according to their medical condition. On this moment only a limited list of medical conditions can be selected, mainly focusing on different types of cancer.

Figure 15: search start through www.zorgkaartnederland.nl

When selecting ‘physiotherapists’ in the starting criteria, a list opens of all physiotherapists for the selected location and gives the following information:

- Name physiotherapist
- Specialization
- Name practice
- Overall appreciation score (0->10) based on feedback from other patients

The list is ordered by appreciation score, with the physiotherapist holding the highest score listed first.

When selecting one service provider, a scorecard opens with following information (appendix 9):

- Same information as mentioned above
- Telephone number
- Link to own webpage
- Overall appreciation score
- Appreciation scores (0->10) on following subcategories: appointments, premises, co-workers, listening skills, information and treatment.
- Links to social media
- Full list of all feedback from other patients
- Map

Reviews and feedback from other customers are the main focus of this information tool. There is only a limited amount of specific information on the services and premises. When selecting a revalidation center or physiotherapy practice, scores based on patient feedback are even given for each individual physiotherapist working in the center.

When starting the search through selecting a specific medical condition, it becomes clear that each specific help line is created through cooperation of NPCF and the relevant patient organization. After selecting a certain condition, an info-page opens up, offering information about the patient organization and what to expect from the tool. Figure 16 shows a screenshot of the starting page for the condition ‘hernia and stenosis’.

Figure 16: Start search for a specific medical condition. www.zorgkaartnederland.nl

When starting the application, the customer can enter following criteria (appendix 10):

- Location
- Distance customer is willing to travel
- Information on symptoms and diagnosis
- Wishes about waiting time
- Wishes about appointments
- Wishes about freedom of choice of doctor
- Other wishes specific for the condition
- Possibility of online reservation system
- Wishes about specific treatment options
- Possibility to select hospital of preference

This results in an alphabetical list of service providers, compliant with the entered preferences. And for each listed service provider the appreciation score based on reviews and feedback from other customers. When opening the scorecard for a specific service provider, there is an extensive list of information:

- Name & address
- Link to own webpages
- Info on possible treatment methods

- Info on what kind of specialists belong to the multi-disciplinary team (what kinds of specialist-nurses, what profession belongs to the standard-team, what specialist can be involved when needed etc.)
- Detailed information on appointments and waiting times for different treatments
- List of practical tips and links

This is a very interesting tool, as it allows the customer time to think about own preferences and important criteria. It has been clearly made with the specific condition in mind, which creates a tool with very specific and useful information.

www.kiesvoorjezorg.nl

This system is a private initiative, in partnership with Ministry of Health. The stated mission of the website is making health care transparent and helping patients in their choice of provider. For service providers it is a tool to make their practice stand out. In an email conversation Charley Beerman, director and co-founder of the website, explains that competition is the driving force behind the creation of the website.

The search starts with the selection of the needed branch of health care service and a specific location or specific specialization, as figure 17 presents.

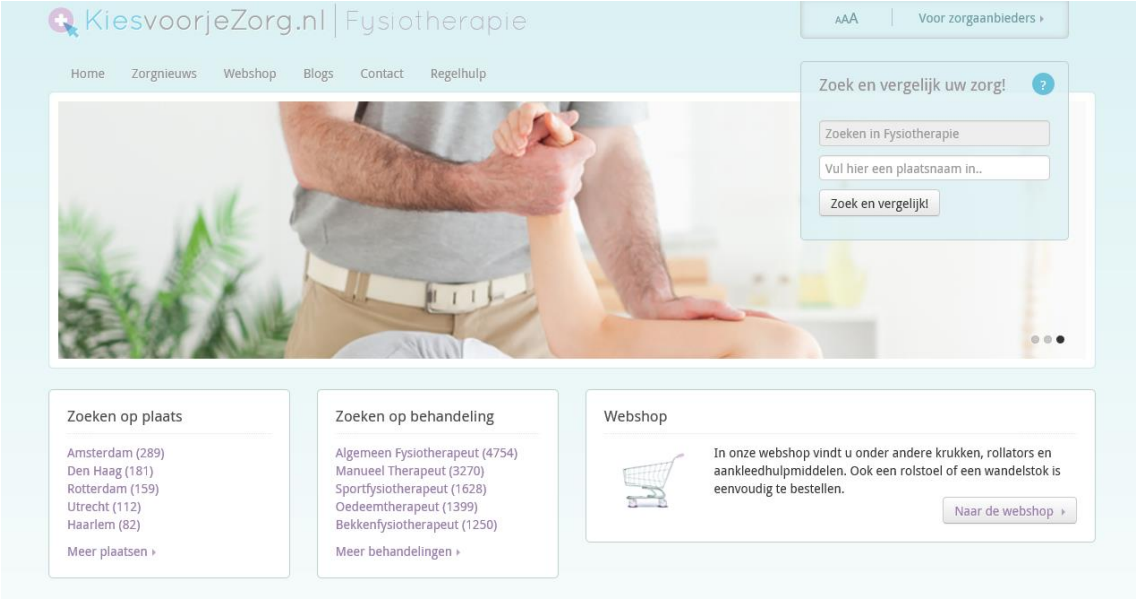

Figure 17: start page www.kiesvoorjezog.nl

The search leads to an alphabetical list which comes with a tool to refine the search. The search can be refined through following criteria:

- Specialization
- Specific facilities
- Specific characteristics of surroundings and premises
- The score card of each service provider gives following information:
- Full address and contact information of provider
- Link for sending an email
- Link to own webpages
- List of specializations
- Facilities
- Mention of possible home-visits
- Information on surroundings and accessibility
- Opening hours
- Names and pictures of each professional in the team
- Pictures of premises
- Map
- Monitor of customer reviews (score 1->10)

Customers can compare providers by selecting them. The system then places their score cards side by side to simplify comparison. Appendix 11 gives screenshots of the results.

Service providers have access to their info card and can share a set of basic information: general information on services, contact information and link to own website. For an added annual fee, providers can add pictures, statements of mission and vision, a logo and the possibility to publish newsletters and articles. Providers who pay the extra fee can also track the activity on their info card. The creators of the website see this added information as a good way to have the provider stand out and attract more customers.

www.independer.nl

The Independer was created to help consumers in their choices. They negotiate with insurance companies about offers, contracts and prices. Recently the Independer was bought by a big insurance company, which challenges their ‘independent’ nature. This information tool on service providers was included in this report, because this tool is co-created with a truly independent, nationwide medical information institution, Mediquest.

This means that they can rely on a big data base for their information on quality. It is mentioned on the website of independer.nl that the information tool has remained fully independent.

The search starts through selecting health care from the main page, onto search and compare for physiotherapy providers. There is a separate link for posting a review on a provider. Customers enter a location and preferred specialization, as presented in figure 18.

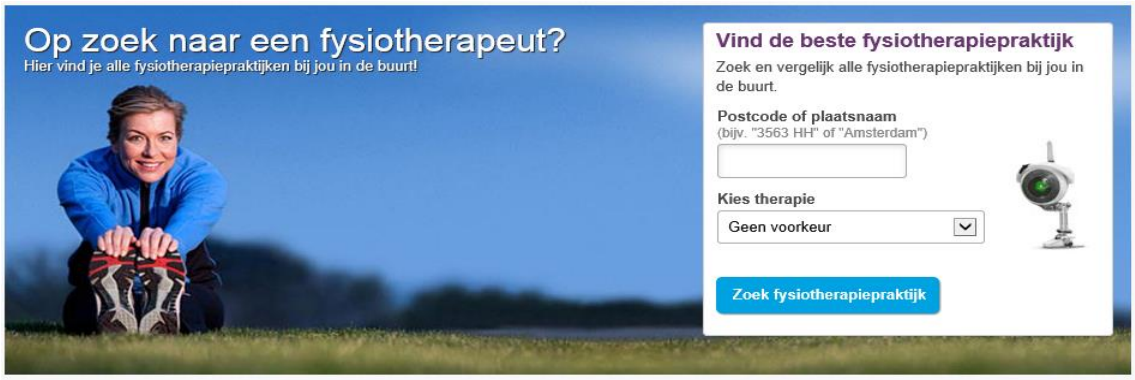

Figure 18. Start search through independer.nl

The search results in a list of providers which customers can order according to their preference: distance to entered location, review score or amount of reviews. Customers can also refine their search. The list holds following information:

- Name & Address
- Distance to entered location
- General appreciation score of customers
- Phone number

When selecting a service provider, following information is presented:

- Name, address, phone number
- General appreciation score
- Links to social media
- Specializations
- Breakdown of customer appreciations core in a score for appointment system, accessibility, cleanliness, customer service, time & attention, information and efficiency of treatment

- Listing of reviews

Appendix 12 gives screenshots of the search process. Mediquest offers information about the physiotherapy service providers and the quality. Providers have no immediate access to their score card, but can contact Mediquest to correct faulty information.

6.2.3 Creation process of the information tools

Creation of www.kiesvoorjezorg.nl

Charley Beerman, director and co-founder of this information system in the Netherlands, explained in an email conversation that market research was done in the creation of the general website and people were asked about how they look for needed information. However, patients were not involved in the creation of information content on physiotherapy service providers. The information content was decided upon by the founders of the site (people with a business background) in cooperation with a private physiotherapy service provider network, Fysiz.

Research on the creation of information tools in the Netherlands

The Dutch Ministry of Health financed a transparency project of 2 years (2011-2012) to increase transparency in rehabilitation. In this project patient organizations, health care insurance companies and health care service providers (rehabilitation centers and specialists) cooperated to identify 20 quality indicators for specialized rehabilitation. A workgroup then developed a frame for translating these indicators to meaningful information on which customers can base their choice of provider. (Bons, Tolsma, Uniken Venema, Ossebaard. 2013).

Bons et al aimed to answer following questions

1. What choice-related information should be selected for publication?
2. What publication methods should be selected to keep information presentation clear?
3. How to increase ease with which information can be found (including navigation possibilities)?
4. What available channels to use for publication of information?

The researchers collected choice-related information specifically for rehabilitation from the following publication channels: Independer, Kiesbeter and Zorgkaart Nederland and listed all criteria with possible choice options.

- General information including name, address, e-mail, website, type of institution, amount of beds, amount of policlinic patients, info on other locations
- Info about care and treatments, including specializations, kinds of rehabilitation, special treatment possibilities.
- Quality indicators, including total appreciation score (0->10), percentage of people who would recommend center, quality score (3-star system), info on particular quality rewards, info on waiting time to first consult and listing of patient reviews and feedback
- Detailed information on quality score: including numbers on safety, results & efficiency, waiting times, certification, cooperation with patient representatives and patient reviews on specific quality indicators.
- Accessibility, including info on distance from entered location, bus connections, parking: free, paid (how much is tariff per hour), how many parking slots for disabled people.
- Premises and facilities, including info on possible info desk, amount of rooms, facilities in room, general facilities (such as library and restaurant), choice menu, info on whether visitors can stay overnight and if there are fixed visiting hours.
- Info on cooperation with other instances

They mention that the organization of information should be a compromise between the information that has priority and logic build-up. Bons et al mention as well that, in case quality indicators are scored, short but clear definitions about the indicator and meaning of score must be given. In case of the quality scores and their presentation, Bons et al considered different methods: star-system, 1->10, words (for example poor, good, excellent), smileys, thumb (up, sideways, down) etc. Bons et al conclude that the star-system for objective product quality indicators and 1->10 for subjective quality experiences are the best systems. Bons et al also conclude that the most important search criteria for rehabilitation are: specialization, specialist, medical condition, treatment method, adult/child and location.

Once these criteria have been selected, the compliant service providers can be ordered in a variety of ways. Bons et al conclude that the customer should be deciding to order the list according to distance, objective quality score, overall appreciation score or waiting time, depending on what is the most important aspect for him/her.

Other important aspects of an information tool for rehabilitation service providers are mentioned in the report

- always mention date and source when publishing data
- score methods and explanation must always be clear and consequent
- when using appreciation scores, mention on how many appreciations this is based
- Sitemap is important
- Anonymous feedback must be possible
- Creator of the tool and their interests are visibly mentioned
- Information must be presented in a clear and simple way
- Possibility to obtain more information is possible

Similar conclusions were made by Bons et al (2013) as were made by Boyce et al (2010) in the UK. All results will be summarized in the following chapter.

6.3 Summary

6.3.1 Comparison information tools

All the tools studied had as a goal to make physiotherapy/rehabilitation services more visible, more transparent in order for patients to be able to make an informed choice.

Along with similarities between all these tools, there are also clear differences. A first distinctive difference is the organization behind the tool. Some tools have been created by governmental organizations, such as ‘NHS Book and Choose’ or kiesbeter.nl. Others have been created in cooperation with patient organizations (zorgkaartnederland.nl), and again others by private entrepreneurs, such as kiesvoorjezorg.nl. Some webpages were created by health care professionals, such as physio2u and others mainly by people with business backgrounds, such as kiesvoorjezorg.nl.

An important aspect to keep in mind is that choice tools initiated by bigger instances such as Ministry of Health and Mediquest in the Netherlands or the NHS in the UK, have a bigger data base, mainly when thinking about quality indicators. Individual web-site creators can never reach a similar amount of data for their information nor can they guarantee objective quality indicators. In the Netherlands the independer.nl is one of those systems that has a big data base on quality because of their cooperation with Mediquest.

When looking at the lists of information content as presented in the previous chapter on each information tool, many similarities and differences can be mentioned. Three different types of information can be seen:

1. Factual information on each provider (such as address, specializations, experiences etc.)
2. Quality information (as measured by quality indicators)
3. Information on experiences of other customers.

Factual information is usually provided by the service provider, quality information should be provided by an independent institution and information on experiences is provided by the service customers.

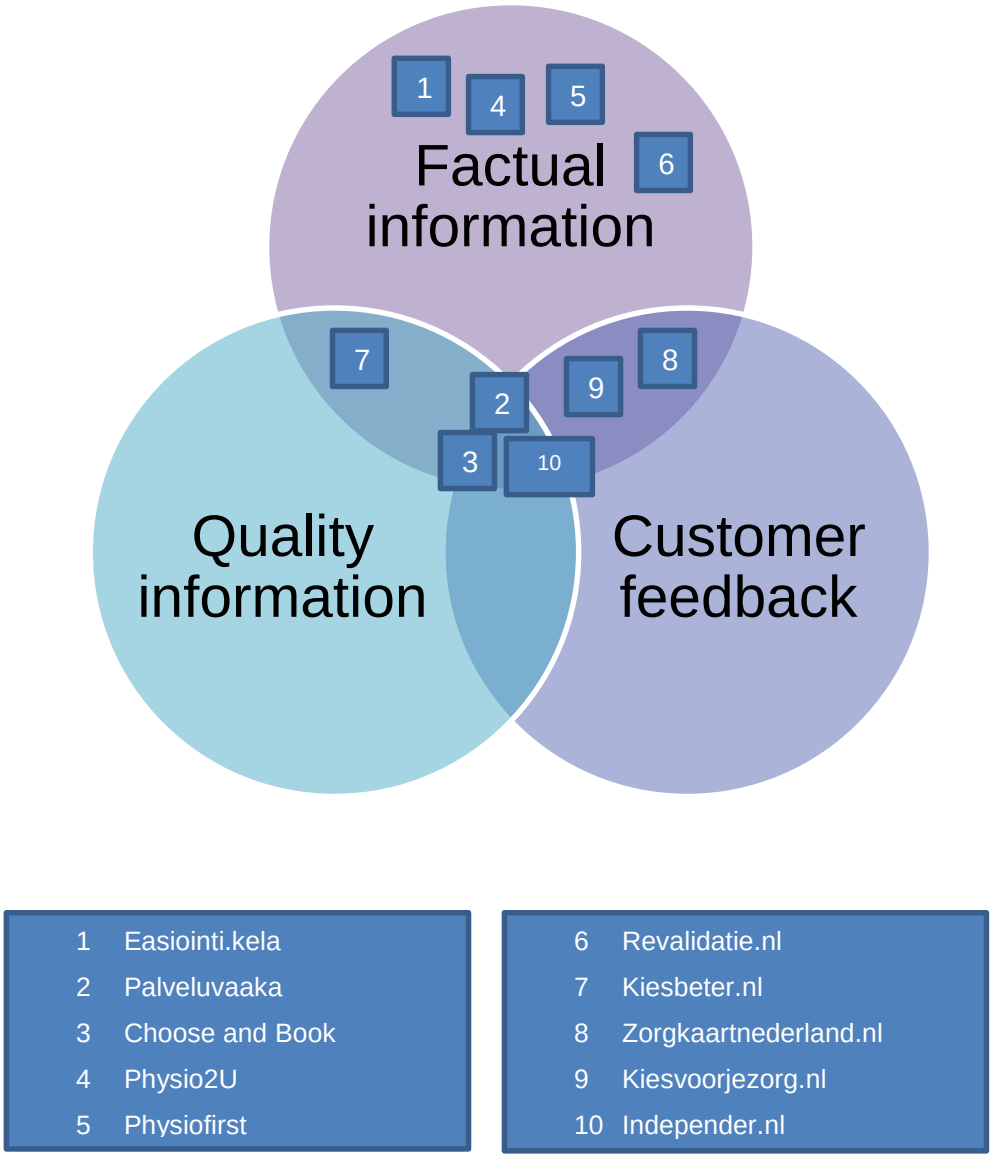

Figure 19: information content of the different information tools.

As figure 19 presents, the listed information tools differ in what kind of information they provide. Some tools are mainly listings of service providers, offering only basic, factual information. Even though this kind of tools can be helpful in giving customers a general idea about the providers (amount of providers, location of each provider …), they don't allow comparison between providers other than which one is closer to home, for example. Certain tools combine factual information with quality information and provide extensive lists with numeric results on quality indicators. An example of such a tool is kiesbeter.nl. Certain tools combine factual information with customer feedback, such as zorgkaartnederland.nl. There are also tools that combine the three different kinds of information.

Another important aspect on which tools differ, aside from the organization behind the creation of a tool and the information content, is the way this information is presented. Big differences can be found in how information is organized, ordered and presented and whether comparison of providers is possible. Also the amount of information ranges from minimal to overwhelming lists of indicators and scores.

Most systems are free for the provider, with exception of a few systems that require a premium for extra services, but not all systems allow full access to own scorecards by the provider. Monetary gain behind creating an information tool, and exchanging more visibility or extra services to those providers that pay a premium, rings alarm bells. To explain the reason for alert it is necessary to refer to what was written about choice theories and the use of 'nudges' in information tools. As an example www.kiesvoorjezorg.nl is used. On this website the listing of providers is decided upon who has paid a premium, with those providers listed first. When connecting this to the knowledge that people tend to choose what is most visible and accessible, with other words, first in the list, people are nudged to choose providers based on who has paid a premium and not based on their own values and needs. It can be decided that the use of this nudge is in the benefit of the provider and not the consumer.

Aside from these differences, a few similarities are found for all systems. The first is that no information tool mentions prices for services. Even though physiotherapy service providers in the Netherlands are obliged to clearly report their prices in their clinics, this does not seem to apply for online transparency. This is rather surprising, since Victoor et al (2012) mentioned in their report on patient choice in the Netherlands that information on cost differences between providers is an important factor if patient choice is to lead to increased cost control in health care. It also is surprising in the light of the EU Directive on patients' rights in cross-border health care adopted by the European Parliament and Council in February 2010, in which the importance of clear information on prices is mentioned (Delnoij & Sauter, 2011).

Information content and quantity, organization and presentation of information and the background and intentions of the creators, all seem to be important aspects in the creation process and all seem to influence the decision-making process. In this light it was surprising to find out how only few tools were actually created based on evidence-based knowledge.

The following chapter is dedicated to provide an overview of the research done in the field of patient choice based on online information tools.

6.3.2 Important aspects in the creation of an information tool.

To be able to understand what a good information tool is, it is important to understand the underlying processes of what information is valued and needed by customers and how customers deal with this information. The following chapter contains an overview of research on these processes and practical advice for the creation process of an information tool.

Because the main purpose of information tools is to help people choose the provider that complies with his/her values, it is important to find out what these values and needs are. Damman, Hendriks, Rademakers, Delnoij and Groenewegen (2009) concluded in their research that consumers state to find many information contents important, but that this is not backed up by their behavior. Consumers don't actually use all this information in their decision-making, and tend to focus more on customer feedback than on quality indicators. For this reason they advise creators to alternate 'hard' facts on quality with 'soft' facts such as customer feedback. Faber and colleagues (2009) state that 50 % of consumers say they place high quality of care as their most important concern when making a choice between providers, but in experiments was found that less than 5 % of the patients acknowledged that the information on quality had actually influenced their decision.

When choosing between hospitals, respondents were not so clear on what kind of information is important to them (Boyce et al, 2010). In their research, Boyce and colleagues found that making people more aware of their preferences and values before the actual choice process, resulted in more systematic use of the information and more efficient decisions. An example of such a tool is the condition-specific tool from zorgkaartnederland.nl. In this tool condition-specific choice criteria are placed in the beginning of the search process, which help customers in shaping their preferences.

Whether nudges can be used in this process is an ethical debate. Boyce et al (2010) concluded that controlled use of nudges can help people make choices more in line with their values and needs, specifically the use of preference nudges. However, it is easy to see how these nudges can be used by policy-makers.

After all, the definition of quality in health care is not clear. Qualitative care to a customer may have a different meaning than qualitative care to a policy-maker or health care professional. The research by Bons et al (2013) is the only research mentioning that the customer should be deciding to order the listing of providers according to what the customer values most: distance, objective quality score, overall appreciation score or waiting time. This is a very different approach than the pre-select nudges defended by Boyce et al (2010).

As was mentioned in the literature review on the processes driving patient choice, certain conditions need to be fulfilled for increasing competition between service providers and creating incentives for increased focus on quality. One of these conditions being the availability of comparable information. Based on this theory it must be concluded that a good information tool should allow the possibility to compare providers.

Damman, Hendriks, Rademakers, Delnoij and Groenewegen (2009) researched how health care consumers process and evaluate comparative health care information and warn against presenting too much information. Consumers are easily overwhelmed. They advise short listings of providers with only the most important information and quality data. They advise the deep-linking approach for those customers that want to get more detailed information. Faber et al (2009) came to the same conclusion: choice of a better-quality hospital increased when less information was presented or when most important information was highlighted. Boyce et al (2010) also concluded that people get easily overwhelmed by the quantity of information and spend only a short amount of time (in many cases only a few minutes) to consult the information. They also warn against too technical and detailed information on quality. Boyce et al (2010) remind that customers in general have difficulties to understand the full meaning of these indicators.

Damman et al (2009) also warned that consumers are easily confused by contradictory quality information. For example, a provider scores well on accessibility of the premises but poorly on timeliness of care. This forces consumers to process more in depth, which requires a lot of energy and focus. They realized customers start to decide more intuitively in these circumstances. This is a rather difficult aspect, since including information on quality is likely to bring some contradictory information. In general people are also suspicious about the terms ‘missing data’, or ‘data not available’ (Boyce et al, 2010). Service providers should do an effort to provide all information, and, in case this is not possible, mention clearly what kind of info is missing and why.

The way information is presented is equally important. Faber et al (2009) found that easy-to-read lay-out (for example the use of star-ratings) makes a clear difference, mainly for elderly consumers and consumers with poor numeracy. Damman et al (2009) also stress the importance of good website design with clear overviews and flexible navigation options. Feedback from customers in the research by Boyce et al (2010) resulted in the use of clear, easily understood labels of indicators (which meant people did not need to dig deeper to understand each indicator), consistent use of easily understood symbols, and, in case of quality comparison, the use of evaluative labels (such as 'poor', 'good', 'excellent').

Figure 20 portrays how the customer's values and needs need to be the main drivers behind information content and structure of an information tool. However, co-creation of content by customers, providers and policy-makers is important to create true value in a customer-centric health care system.

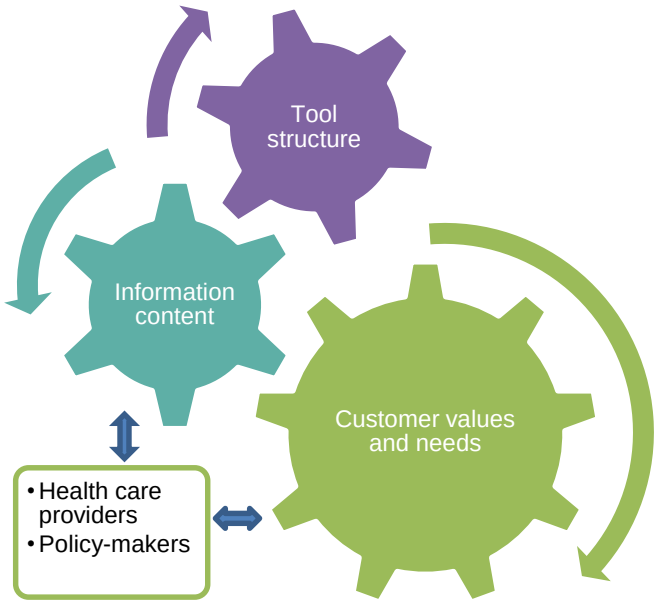

Figure 20: Mechanics of the co-creation of information tools in health care

7 Pilot study of information needs in customer choice

7.1 Objectives

The second part of this study will focus completely on patient choice for Finnish severely disabled people receiving rehabilitation service through Kela and the people helping them in their decisions. Patient choice is a relatively new concept in Finland and very little research has happened, certainly geared towards specific patient groups.

The objective of this pilot study was to find out how important choice among physiotherapy service providers is to severely disabled people receiving rehabilitation services through Kela and the people helping them in their decisions. Another major objective was to find out what kind of information these customers need to make an informed choice. Additionally is studied what the preferred sources are for this kind of information and how satisfied customers are with the currently available information.

7.2 Data

7.2.1 Target group

The target group for this research are severely disabled people, aged 0 to 65 and entitled to rehabilitation services from the Social Insurance Institution of Finland (Kela). Included in the target group are family members, carers and professionals helping with their decisions. The target group was reached through cooperation with patient organizations. The list of patient organizations on the webpage of *Helsingin ja Uudenmaan Sairaanhoitopiiri* (HUS) was used for selection of appropriate organizations and their contact information. The organizations listed in table 1 responded positively and helped in posting the survey on their websites and reached customers through their Facebook pages.

Table 1: Patient organizations	
Patient organizations	**Target group**
Finnish Association of Spinal Cord Injured Akson ry	People with spinal cord injuries
Jaatinen Vammaisperheiden Monitoimi-keskus ry	Families with a severely disabled child
Aivovammaliitto ry	People with brain injuries
Tatu ry	Families with severely disabled or chronically ill children
Suomen Tule ry	People & organizations working in the context of musculoskeletal dysfunctions
Invalidiliitto	People with mobility disabilities
Fysi ry	Finnish physiotherapists
MS-Liitto	People with MS and rare progressive neuro-logical diseases
Kevyt ry	Parents of premature babies.

Thanks to the involvement of these patient organizations it was possible to reach a sample from all over Finland, with a diversity in diagnoses and of different ages. It also allowed to collect data without needing access to official patient registers.

7.2.2 Data collection process

Data was collected by a web-based survey, which consists of a cover letter and a short questionnaire (Appendix 1). The survey was created using E-lomake and the structure and content were created partly based on specific needs from Kela. Existing online information systems in the Netherlands (www.kiesvoorjezorg.nl) and England (physio2u from www.csp.org.uk) and research done in the field of information content and patient choice were utilized (Coulter & Magee 2003; Boyce, Dixon, Fasolo, Reutskaja 2010). The questionnaire was first written in English and later translated to Finnish.
The survey was constructed in such a way that a decision from an ethical committee would not be needed. No questions are asked about diagnosis or specific personal information.

7.2.3 Questionnaire

The first five questions deal with general information: age (in years), gender, home municipality, motivational background (customer/patient, family/carer, professional or other) and educational level. The following 2 questions deal with general attitude towards choice in health care. Respondents could answer using a 5-point Likert-like scale ranging from ‘fully agree’ to ‘fully disagree’.

They used this scale to answer on which level they agree/disagree with statements on how important freedom of choice is between health care service providers and on how available information currently is on these providers in order to make an informed choice.

The exact phrasing of these questions in English and in Finnish:

- The possibility to choose among health care service providers is important for me.
    - Mahdollisuus valita terveydenhuollon palveluntuottaja on minulle tärkeä.
- I find it easy to find sufficient information that enables me to make a choice between health care service providers.
    - Terveydenhuollon palveluntuottajista on minusta helppoa löytää riittävästi tietoa parhaan mahdollisen valinnan tekemiseen.

The following question deals with the preferred source of information. Respondents could choose among seven options which one they regard as the best source for giving information on health care service providers. These options were health care professionals, Kela, friends/family, commercial ads, internet, patient organizations and elsewhere (including the possibility to specify).

The following part of the questionnaire asks respondents to mark to which degree they value different aspects of information on physiotherapy service providers. There are 13 separate information aspects and respondents answer using a 5-point Likert-like scale, varying from ‘very important’ to ‘not important’. The 13 aspects deal with general information on service providers, such as location, accessibility of the premises, opening hours, providers’ own web pages and pictures of the premises, specific information about the therapist, such as specializations, work experience, language skills and gender and questions concerning quality of treatment, such as treatment efficiency, effectiveness and safety.

The questions concerning quality of care were constructed using the definition and basic concepts of health care from the World Health Organization. The basic concepts of quality in care are: effectiveness, efficiency, accessibility, patient-centricity, equitability and safety (WHO, 2006).

Finally respondents were asked, in an open question, about any other information they value in the choice process between service providers.

The whole survey could be answered in 5 minutes and was activated online from 1.3.2014 until 30.5.2014.

7.2.4 Sample

The survey was answered by 34 persons (n=34).

The histogram in figure 21 shows the distribution of the age of the sample, which is normal (Kolmogorov-Smirnov, p=.776). Age ranges between 21 and 62 years.

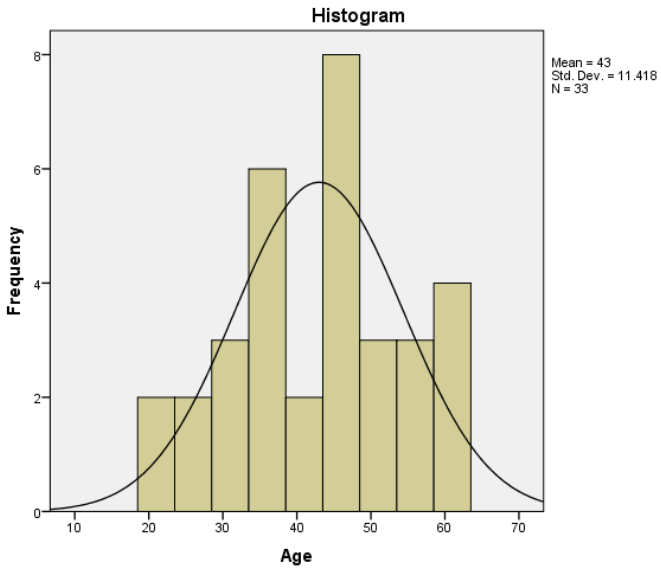

Figure 21: Sample age histogram.

For some analyses the sample has been grouped for age: 20 to 34 years, 35 to 49 years and 50 to 64 years. Table 2 represents distribution of the sample in age groups and other demographic information, including levels of distribution for each parameter.

Table 2: Frequencies and percent grouped for age groups (15y), gender, home municipality, motivational background and educational level.

		Frequency	Percent (%)
Age groups 15y	20->34 35->49 50->64 Missing **Total** **Chi² p=.178 (normal)**	8 16 9 1 **34**	23.5 47 26.5 3 **100**
Gender	Male Female **Total** **Binomial p=.000 (abnormal)**	3 31 **34**	9 91 **100**

Home municipality (types)	Urban Semi-urban Rural Missing **Total** **Chi² p=.000 (abnormal)**	29 2 2 1 **34**	85 6 6 3 **100**
Motivational background	Customer/patient Family/carer Professional **Total** **Chi² p= .013 (abnormal)**	18 12 4 **34**	53 35 12 **100**
Educational level	No vocational degree Vocational degree Higher degree **Total** **Chi² p=.572 (normal)**	9 11 14 **34**	27 32 41 **100**

The sample consists of respondents from different age groups and different educational levels. However, there is an overrepresentation of female respondents and respondents living in urban municipalities. The questionnaire was mainly answered by severely disabled people and their family members/carers. A minority answering the questionnaire were professionals working with severely disabled people.

The full list of home municipalities can be found in appendix 13. To enable meaningful interpretation of the results, home municipalities were grouped in municipality types: urban, rural and semi-urban, as described by Statistics Finland (Kunnat, 2014).

The questionnaire was answered by severely disabled people, their family or carers and professionals helping severely disabled people. This variable was labeled as motivational background, referring to different motivations for answering the questionnaire. Four answer options were available for this variable: ‘customer/patient’, ‘family/carer’,’ professional’ and ’other’. Nobody chose for the option ‘other’ and that is why this option is left out when describing groups and results.

To facilitate interpretation of results, the decision was made to reduce the groups for educational level. ‘Primary education’ and ‘upper secondary education’ were marked as ‘no vocational degree’, ‘vocational education’ as ‘vocational degree’ and ‘degree education’ and ‘higher degree education’ as ‘higher degree’.

7.2.5 Methodology

Data was collected and transferred from E-lomake to Excel and to an SPSS database. Excel was partly used for descriptive analysis and SPSS was used for descriptive and inferential, quantitative data analysis.
Distribution levels for all demographic parameters are included in table x. and demonstrate that distribution is abnormal for all variables, except for the variables of age and educational background. Appendix 14 gives a list of levels of distribution for all variables.
The fact that distribution of most variables is abnormal limits statistical analysis and the possibility to generalize to the whole population of severely disabled patients in Finland receiving rehabilitation services through Kela, their carers and professionals helping them in their decisions.
According to Kela Statistics the total population in Finland of severely disabled people receiving physiotherapy services through their network in 2013 is approximately 14 500 (Kelasto). With this number in mind, the survey sample of 34 is small and this also limits the possibility to generalize.
During the process of statistical analysis, main focus has been on non-parametric statistics, because they do not require any assumption about the shape of the underlying population distribution (Argyrous, 2005).

For calculating the levels of association between the variables, the statistics guide by Argyrous (2005) was used. The table for different measures of association and their data considerations can be found in appendix 15.
According to Argyrous (2005) attitudes are essentially continuous data, even though ordinal scales are used. This is the motivation behind the use of the Spearman's rho as level of association. Whenever this test is used, it is calculated on the full 5-point scale and the full age scale, so not on the grouped variables. Spearman's rho will be calculated and mentioned in this report every time the conditions allow it.

When looking at the results it is important to keep in mind that this survey is a pilot study, a first step in the valuable process of finding out about customer choice in Finland.

7.2.6 Limitations and strengths

There are a few limitations that need to be highlighted before looking at the results. The principal limitation is the framing of the sample. Only people connected to a patient organization are included in this study. It was not possible to find exact numbers on how many severely disabled people and their family/carers belong to a patient organization. A second limitation is the fact that access to the survey and answering the survey are conditioned by access to a computer. With these limitations in mind, it goes beyond saying that a wider, more thorough study is needed to allow generalizing of the results to the whole population of severely disabled people receiving rehabilitation services through Kela.

Looking at the gender distribution in the sample, there is a clear overrepresentation of female participants. Based on the available information it is impossible to explain this overrepresentation. It may point at the possibility that women are more interested than men in answering online surveys. Smith (2008) found in his research a significant gender influence in online survey participation among university faculty members, with women being more active than men. But it was difficult to find any other proof that women answer surveys more readily than men. It must also be mentioned that all the respondents who answered the survey as family members or carers are women. Siljander (2012) mentions in his research that in 2012 69% of Finnish carers were women.

Another observation is that the survey was mainly answered by customers/patients and their family members and carers. This was one of the main objectives for this study: to find out what kind of information patients and their carers value. And it may be expected that patient organizations reach mainly this target group and less professionals.

Regardless of the limitations and the difficulty to generalize the results to the whole population of severely disabled patients and their carers in Finland, this study gives a valuable first impression of the appreciation of patient choice among this population, and their need for specific information. It is a first step in a country where patient choice is relatively new. This pilot study also points out many opportunities for future research.

8 Results of the pilot study

One of the first, most important questions this study wants to answer, is whether severely disabled people and the persons helping them in their decisions, value the freedom of choice between health care service providers.
As the pie chart in figure 22 portrays, freedom of choice is important or very important to the majority (94 %) of respondents.

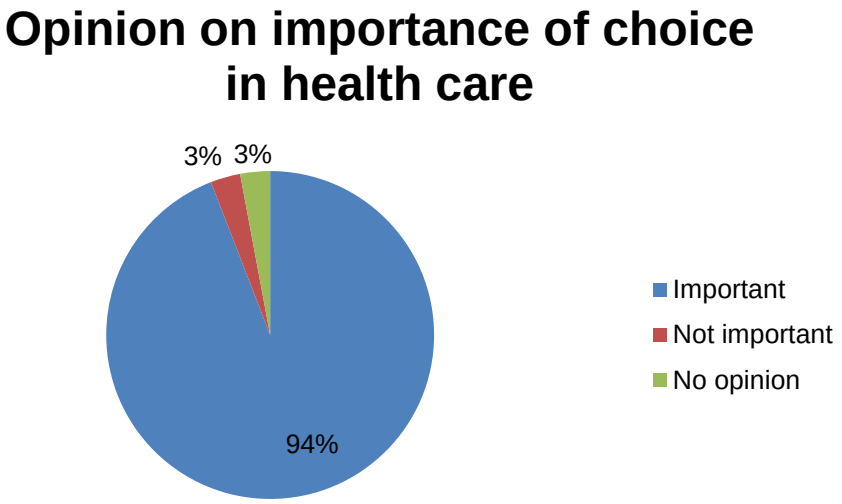

Figure 22: Pie chart (percent) of opinion on importance of choice between health care providers.

There is no difference between men and women in appreciation of freedom of choice. Table 3 presents the results for the crosstabulation. The Mann-Whitney U test shows no significant difference (p = .819) between gender and opinion on importance of choice.

Table 3: Crosstabulation gender and choice importance.

		Gender		
		Female Percent (n)	Male Percent (n)	Total Percent (n)
Opinion on importance of choice in health care	Important	94 (29)	100 (3)	94 (32)
	Not important	3 (1)	0 (0)	3(1)
	No opinion	3 (1)	0 (0)	3 (1)
	Total	100 (31)	100 (3)	100 (34)
	Goodman-Kruskal tau = 0.004			
	Mann-Whitney U test Z = -.328			

	Exact Sig. = .819

Older people seem to value the freedom of choice less than younger persons. As presented in table 4, a very mild, negative association (Spearman's rho = - 0.133) can be found between opinion on importance of choice and age, which indicates that freedom of choice becomes decreasingly important with increasing age.

Table 4: Crosstabulation between age groups and choice importance.

		Age groups			
Opinion on importance of choice in health care		20->34 % (n)	35->49 % (n)	50->64 % (n)	Total % (n)
	Important Not important No opinion	100 (8) 0 (0) 0 (0)	94 (15) 0 (0) 6 (1)	89 (8) 11 (1) 0 (0)	94 (31) 3 (1) 3 (1)
	Total Spearman's rho = - 0.133 (p=.369)	100 (8)	100 (16)	100 (9)	100 (33)

Choice is important to the majority of respondents in each age group, but the percentages diminish slightly. All respondents aged 20->34 find choice between health care providers important, 94% of people aged 35->49 and 89% of people aged 50->64 share this opinion.

The Kruskal-Wallis test was used to see if this trend is significant, but the p-value of .584 shows that there is no significant difference between people of different ages and their opinion on how important freedom of choice is.

In this case the Kruskal-Wallis H test for two or more independent samples (which uses rank-order) was used as a non-parametric alternative to a one-way between-groups analysis of variance. Results from this test are presented in table 5.

Table 5: Kruskal-Wallis H test for age groups-opinion on importance of choice

	Age groups		
	Chi-Square	df	Exact Sig.
Opinion on importance of choice in health care	1.131	2	.584

The living environment people live in does not influence how people value the freedom of choice. Results for the crosstabulation between municipality type and opinion on importance of choice are presented in table 6. The Goodman-Kruskal tau measure (= 0.007) shows that there is no association between these two variables.

Table 6: Crosstabulation municipality type and choice importance.

		Municipality type			
		Urban % (n)	Semi-urban % (n)	Rural % (n)	Total % (n)
Opinion on importance of choice in health care	Important Not important No opinion	93 (27) 3,5 (1) 3,5 (1)	100 (2) 0 (0) 0 (0)	100 (2) 0 (0) 0 (0)	94 (31) 3 (1) 3 (1)
	Total Goodman-Kruskal tau= 0.007	100 (29)	100 (2)	100 (2)	100 (33)

Professionals helping patients in their decisions find the freedom of choice between health care professionals significantly less important than patients and their family members/carers.

Table 7 presents the responses on importance of choice grouped by motivational background, and interestingly hardly any association could be found between motivational background and opinion on importance of choice (Goodman-Kruskal tau = 0.085). However, the Kruskal-Wallis test points at a significant effect (p = .034) from motivational background on opinion on importance of choice.

Table 7: Crosstabulation motivational background and choice importance.

		Motivational background			
		Customer/patient % (n)	Family/carer % (n)	Professional % (n)	Total % (n)
Opinion on importance of choice in health care	Important Not important No opinion	100 (18) 0 (0) 0 (0)	83 (10) 8,5 (1) 8,5 (1)	100 (4) 0 (0) 0 (0)	94 (32) 3 (1) 3 (1)
	Total Goodman-Kruskal tau = 0.085	100 (18)	100 (12)	100 (4)	100 (34)

	Kruskal-Wallis Test Chi-square = 6.840 Df = 2 Exact Sig. = .034*

*: significant to the 0.05 level

The mean values portrayed in table 8 indicate that professionals find freedom of choice slightly but significantly less important than patients and their carers.

Table 8: Median values of opinion on importance of choice for patients, family/carers and professionals	
Motivational background	Opinion on importance of choice
Customer/patient **Family / carer** **Professional** **Total**	5.00 (=fully agree that freedom of choice is important) 5.00 4.50 (=agree that freedom of choice is important) 5.00

When looking at the results for the crosstabulation between educational level and opinion on importance of choice, an interesting trend can be seen. As portrayed in table 9, there is a mild, negative association (Spearman's rho= -0.377) between educational level and opinion on importance of choice, with importance of choice mildly decreasing with increasing educational level. So people with a higher degree mention slightly more often that they don't value freedom of choice.

Table 9: Crosstabulation educational level and choice importance.					
		Educational level			
		No voc. degree % (n)	**Voc. degree % (n)**	**Higher degree % (n)**	**Total % (n)**
Opinion on importance of choice in health care	**Important** **Not important** **No opinion**	100 (9) 0 (0) 0 (0)	100 (11) 0 (0) 0 (0)	86 (12) 7 (1) 7 (1)	94 (32) 3 (1) 3 (1)
	Total **Spearman's rho = -0.377 (p = .028)**	100 (9)	100 (11)	100 (14)	100 (34)

Table 10 shows the results when performing a Kruskal-Wallis H Test. We see a small p-value (= .076), but this is not statistically significant to the .005 level, so it is not possible to say that there is a significant difference in opinion on importance of choice across the groups with different educational level.

Table 10: Kruskal-Wallis test for educational level-opinion on importance of choice			
	Educational level		
	Chi-Square	df	Exact. Sig.
Opinion on importance of choice in health care	5.160	2	.076

When people are willing and able to choose, there must be information on which such a choice can be based. Respondents were asked how available such information currently is. As figure 11 presents, half of the respondents (50 %, n = 17) have difficulties finding sufficient information on physiotherapy providers. A minority of 4 respondents (12 %) has no opinion on this matter and 13 respondents (38 %) claim to find sufficient information.

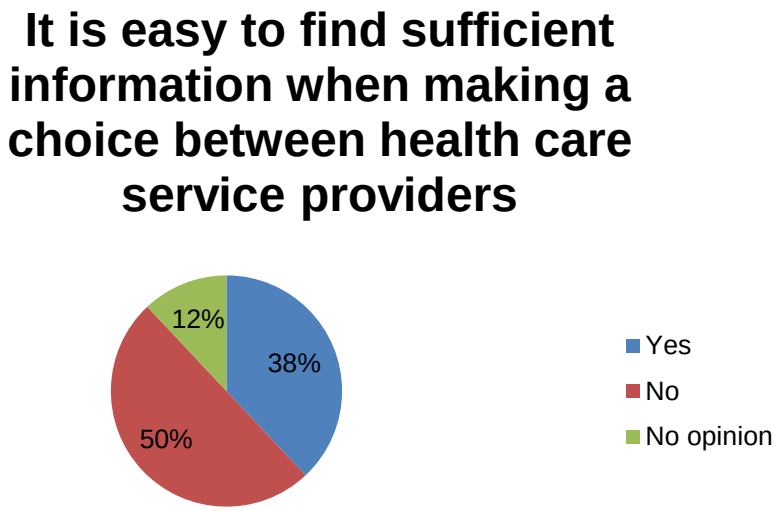

Figure 11: Pie chart (percent) of opinion on availability of information on health care providers.

To find out if men and women find information equally available, a crosstabulation was performed. Results in table 12 show that men find information more easily available than women, but this can not be proven statistically (p = .705).

Table 12: Crosstabulation gender and opinion on information availability.				
		Gender		
		Female % (n)	Male % (n)	Total % (n)
It is easy to find sufficient information during the choice-making process	Yes No No opinion	35 (11) 52 (15) 13 (4)	67 (2) 33 (1) 0 (0)	38 (13) 50 (17) 12 (4)
	Total Lambda = 0.059	100 (31)	100 (3)	100 (34)
	Chi-square Test Pearson Chi-square value = 1.266 Df = 2 Exact Sig. (2-sided) = .705			

An interesting trend can be seen when crosstabulating age groups and opinion on information accessibility (table 13). With increasing age people seem to find information less accessible. The Spearman's rho test shows this mild, negative association (-0.220).

Table 13: Crosstabulation between age groups and opinion on information accessibility.					
		Age groups			
It is easy to find sufficient information during the choice-making process		20->34 % (n)	35->49 % (n)	50->64 % (n)	Total % (n)
	Yes **No** **No opinion**	63 (5) 37 (3) 0 (0)	31 (5) 50 (8) 19 (3)	22 (2) 67 (6) 11 (1)	36 (12) 52 (17) 12 (4)
	Total **Spearman's rho = -0.220**	100 (8)	100 (16)	100 (9)	100 (33)

More than half (63 %) of the respondents aged 20->34 claim to easily find information for making a choice between health care service providers, opposed to people aged 50 -> 64, of whom more than half (67 %) have difficulties finding information.

The Kruskal-Wallis test (table 14) indicates that this difference is not significant (p = .255).

Table 14: Kruskal-Wallis H test for age groups and availability of information			
	Age groups		
	Chi-Square	Df	Exact Sig.
Availability of information	2.780	2	.255

People living in urban areas do not differ from people living in semi-urban or rural areas in their opinion on accessibility of information. The crosstabulation (table 15) indicates that about half (55 %, n = 16) of the respondents living in urban municipalities find it difficult to find information on which to make a choice between health care providers, which is relatively similar to what can be found among respondents living in rural areas (50 %, n = 1). The Kruskal-wallis test shows no statistically significant difference between the people living in different municipality types and their opinion on information availability.

Table 15: Crosstabulation municipality type and opinion on information accessibility.					
		Municipality type			
		Urban % (n)	Semi-urban % (n)	Rural % (n)	Total % (n)
It is easy to find sufficient information during the choice-making process	**Yes** **No** **No opinion**	38 (11) 55 (16) 7 (2)	0 (0) 0 (0) 100 (2)	50 (1) 50 (1) 0 (0)	36 (12) 52 (17) 12 (4)
	Total **Lambda = 0.125**	100 (29)	100 (2)	100 (2)	100 (33)
	Kruskal-Wallis test Chi-square = .499 Df = 2 Exact Sig. = .807				

When looking at people's motivation for participating in the survey, it is interesting to see that more than half of the patients (56 %, n = 10) say that they find sufficient information for making a choice, but not a single professional found information easily accessible. More than half of family/carers (58 %, n = 7) and all professionals say not to find sufficient information for making such a choice.

The crosstabulation is presented in table 16.

Table 16: Crosstabulation motivational background and information accessibility.

		Motivational background			
		Custom-er/patient % (n)	Fami-ly/carer % (n)	Profes-sional % (n)	Total % (n)
It is easy to find suffi-cient infor-mation dur-ing the choice-making process	**Yes** **No** **No opinion**	56 (10) 33 (6) 11 (2)	25 (3) 58 (7) 17 (2)	0 (0) 100 (4) 0 (0)	38 (13) 50 (17) 12 (4)
	Total **Lambda =0.235**	100 (18)	100 (12)	100 (4)	100 (34)

When looking at the Lambda value (= 0.235), a mild level of association can be seen between motivational background and opinion on accessibility of information.
However, the Chi-square test of independence gives a p-value of .129 (table 17), which means that whether a person is a patient, a family member or a professional will not influence the opinion on availability of information when making choices between health care service providers.

Table 17: Chi-square Test for motivational background and availability of information.

	Motivational background		
	Pearson Chi-square value	Df	Exact Sig. (2-sided)
Availability of in-formation	7.380	4	.129

People with higher education have more difficulties finding sufficient information than people with lower educational backgrounds. The results for the crosstabulation are presented in table 18.

Table 18: Crosstabulation educational level and opinion on availability of information.					
		Educational level			
		No voc. degree % (n)	**Voc. degree % (n)**	**Higher degree % (n)**	**Total % (n)**
It is easy to find sufficient information during the choice-making process	**Yes** **No** **No opinion**	56 (5) 44 (4) 0 (0)	46 (5) 18 (2) 36 (4)	21 (3) 79 (11) 0 (0)	38 (13) 50 (17) 12 (4)
	Total **Spearman's rho = -0.179 (p=.223)**	100 (9)	100 (11)	100 (14)	100 (34)

The level of association only points at a mild, negative association between educational level and opinion on availability of information. However, when performing a Chi-square test for independence (table 19), we find a statistically significant difference between the groups (p = .005).

Table 19: Chi-square Test for educational level and availability of information.			
	Educational level		
	Pearson Chi-square value	Df	Asymp. Sig. (2-sided)
Availability of information	14.823	4	.005*

*= significant to the .005 level.

The median values presented in table 20, indicate that people with increasing level of education find it decreasingly easy to find sufficient information when making a choice between health care service providers.

Table 20: Median values of opinion on availability for people with different educational background	
Motivational background	Opinion on availability of information
No vocational degree **Vocational degree** **Higher degree** **Total**	4.00 (=it is easy to find available information) 3.00 (=no opinion) 2.00 (= it is not easy to find available information) 2.50

These results may be interpreted that people with higher education require more information to feel like they have sufficient information to base the choice on.

When looking for information during the decision process between service providers, people prefer or use different sources. Respondents were asked to choose the one source they felt provides them best with the necessary information.
Of the 34 respondents, 6 opted for 'elsewhere'. Based on the given specification of where the information was found, it was decided to place 3 answers among the category 'health care professionals'. These specifications were: 'from other therapists', 'previous physiotherapist' and 'service provider'. Two answers were more difficult to place under another source and remained as 'elsewhere'. These were: 'other patients/customers' (*toisilta kuntoutettavilta*) and 'peer support' (*vertaistuki*). One respondent did not give any specification and was categorized as 'missing'.
Table 21 provides information on preferred source of information among the respondents.

Table 21: Frequency and percent of preferred information source

		Frequency	Percent (%)
Info source	Health care professionals	17	50
	Internet	8	23
	Family/friends	3	9
	Kela	2	6
	Elsewhere	2	6
	Patient organizations	1	3
	Missing	1	3
	Commercial ads	0	0
	Total	**34**	**100**

Health care professionals are mentioned as the best source of information when making a choice between health care service providers by half of the sample (50 %, n=17). Internet is mentioned as the preferred source by 23 % (n=8) of the respondents, family and friends are preferred by 9% (n=3). A minority of the respondents look for information from Kela (6 %) or elsewhere (6 %), specified as fellow patients and peers.

Men prefer internet and family/friends as sources for information on providers and women mainly turn to health care professionals. However, this could not be tested statistically in this sample.

Table 22 presents the results for the crosstabulation between gender and preferred source of information.

Table 22: Crosstabulation gender and preferred source of information.

		Gender		
		Female % (n)	Male % (n)	Total % (n)
Preferred source of information	Health care professionals	55 (17)	0 (0)	51 (17)
	Internet	23 (7)	50 (1)	24 (8)
	Family/friends	6 (2)	50 (1)	9 (3)
	Kela	6 (2)	0 (0)	6 (2)
	Elsewhere	7 (2)	0 (0)	6 (2)
	Patient organizations	3 (1)	0 (0)	3 (1)
	Missing		(1)	
	Total Lambda = 0.063	100 (31)	100 (2)	100 (33)

With increasing age, people turn less towards health care professionals when looking for information on service providers and look more online. Table 23 represents the crosstabulation between age groups and preferred information sources.

Table 23: Crosstabulation between age groups and preferred information source.

		Age groups			
Preferred source of information		20->34 % (n)	35->49 % (n)	50->64 % (n)	Total % (n)
	Health care professionals	62,5 (5)	56 (9)	33 (3)	51 (17)
	Kela	0 (0)	13 (2)	0 (0)	6 (2)
	Family/friends	12,5 (1)	6 (1)	11 (1)	9 (3)
	Internet	12,5 (1)	19 (3)	45 (4)	24 (8)
	Patient organizations	12,5 (1)	0 (0)	0 (0)	3 (1)
	Elsewhere	0 (0)	6 (1)	11 (1)	6 (2)
	Total **Lambda = 0.063**	100 (8)	100 (16)	100 (9)	100 (33)

More than half of the respondents aged 20->43 (62,5 %, n= 5) turn to health care professionals, opposed to 56 % (n=9) of respondents aged 35->49 and 33 % (n=3) of people aged 50->64. Internet is used more by older people, 45 % of people aged 50->64 and only by 19 % of people aged 35->49 and by 12,5 % of people aged 20-> 34.

However, the chi-square test for independence (table 24) indicates that there is no statistical difference (p = .548) between the age groups for preference of information source.

Table 24: Chi-square Test for age groups and preferred information source.

	Age groups		
	Pearson Chi-square value	Df	Exact Sig. (2-sided)
Preferred source of information	9.403	10	.548

The Lambda measure (= 0.063) indicates that there is hardly an association between municipality type and preference for information sources.

As presented in table 25, people living in urban municipalities prefer similar sources than people living in semi-urban or rural municipalities.

Table 25: Crosstabulation municipality type and preferred source of information.

		Municipality type			
		Urban % (n)	Semi-urban % (n)	Rural % (n)	Total % (n)
Preferred source of information	**Health care professionals**	55 (16)	0 (0)	50 (1)	52 (17)
	Kela	7 (2)	0 (0)	0 (0)	6 (2)
	Family/friends	7 (2)	50 (1)	0 (0)	9 (3)
	Internet	24 (7)	0 (0)	50 (1)	24 (8)
	Patient organizations	3,5 (1)	0 (0)	0 (0)	3 (1)
	Elsewhere	3,5 (1)	50 (1)	0 (0)	6 (2)
	Total **Lambda = 0.063**	100 (29)	100 (2)	100 (2)	100 (33)

Do patients use different sources than carers or professionals?

The crosstabulation (table 26) between motivational background and preferred information source and the Lambda level show that there is no association between these two variables.

Table 26: Crosstabulation motivational background and preferred source of information.

		Motivational background			
		Custom-er/patient % (n)	Family/carer % (n)	Professional % (n)	Total % (n)
Pre-ferred source of infor-mation	**Health care professionals**	47 (8)	59 (7)	50 (2)	52 (17)
	Kela	6 (1)	8 (1)	0 (0)	6 (2)
	Family/friends	12 (2)	8 (1)	0 (0)	9 (3)
	Internet	23 (4)	17 (2)	50 (2)	24 (8)
	Patient organizations	0 (0)	8 (1)	0 (0)	3 (1)
	Elsewhere	12 (2)	0 (0)	0 (0)	6 (2)
	Total **Lambda =0.000**	100 (17)	100 (12)	100 (4)	100 (33)

Health care professionals are mentioned most frequently as preferred source by customers/patients and carers. Half of the professionals turn to other health care professionals for information and half looks online.

Based on the Chi-square test (table 27), it must be concluded that a person's motivational background is independent (p = .871) from what source he or she prefers.

Table 27: Chi-square Test for motivational background and preferred information source.

	Motivational background		
	Pearson Chi-square value	Df	Exact Sig. (2-sided)
Preferred source of information	6.041	10	.871

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The respondent's educational level does not influence which information source the person prefers. However, the importance of health care professionals as a source seems to diminish and the internet seems to gain popularity with increasing educational level. The results of the crosstabulation are presented in table 28. No association (Lambda = 0.000) can be found between a person's educational level and the information source a person prefers. Health care professionals are the main source of information for all three groups, but respondents without a vocational degree turn to health care professionals the most (67 %, n = 6).

However, the Chi-square test (p = .314) shows that people with different educational levels do not prefer different sources for information when making a choice between different health care service providers

Table 28: Crosstabulation educational level and preferred source of information.					
		Educational level			
		No degree % (n)	**Voc. degree % (n)**	**Higher degree % (n)**	**Total % (n)**
Preferred source of information	**Health care professionals**	67 (6)	46 (5)	46 (6)	52 (17)
	Kela	0 (0)	9 (1)	8 (1)	6 (2)
	Family/friends	22 (2)	9 (1)	0 (0)	9 (3)
	Internet	11 (1)	18 (2)	38 (5)	24 (8)
	Patient organizations	0 (0)	0 (0)	8 (1)	3 (1)
	Elsewhere	0 (0)	18 (2)	0 (0)	6 (2)
	Total **Lambda = 0.000**	100 (9)	100 (11)	100 (13)	100 (33)
	Chi-square Test Pearson Chi-square value = 11.640 Df = 10 Exact Sig. (2-sided) = .314				

When performing a crosstabulation and chi-square test, a significant difference (p = .009) was found between the source a person uses for finding information and the opinion on information availability. Table 29 represents the crosstabulation between these two variables and the result for the chi-square test.

When looking at the percentages, we can say that 75 % of people who are satisfied with the current, available information get this information from health care professionals.

In the light of this research it is interesting to see that 87% of people (n=7) who look for information online are not happy with the available information.

Table 29: Crosstabulation opinion on availability of information and preferred info source.

			It is easy to find sufficient information to make a choice between providers		
			No opinion	**No**	**Yes**
Preferred source of information	**Health care professionals**	N % within Info source % within info availability % of total	1 6 25 3	7 41 41 21	9 53 75 27
	Kela	N % within Info source % within info availability % of total	0 0 0 0	1 50 6 3	1 50 8 3
	Family/friends	n % within Info source % within info availability % of total	1 33 25 3	1 33 6 3	1 33 8 3
	Internet	n % within Info source % within info availability % of total	0 0 0 0	7 87 41 21	1 12 8 3
	Patient organizations	n % within Info source % within info availability % of total	0 0 0 0	1 100 6 3	0 0 0 0
	Elsewhere	n % within Info source % within info availability % of total	2 100 50 6	0 0 0 0	0 0 0 0
	Total	N % within Info source % within info availability % of total	4 12 100 12	17 51 100 51	12 36 100 36
Lambda – Symmetric = 0.156					
Chi-square Test **Pearson Chi-square value = 23.517** **Df = 10** **Exact Sig. (2-sided) = .009***					

*= significant to the .05 level.

An important aim of this study is to provide necessary information in the construction process of an information tool, for which content of information is a very important aspect.

In the questionnaire respondents were asked what kind of information they need and value most when making a decision between physiotherapy service providers. Table 30 gives an overview of opinions on importance of 13 different information aspects.

Table 30: Frequency and percent of information aspects

	Not at all important % (n)	Not very important % (n)	Fairly important % (n)	Important % (n)	Very important % (n)	Total % (n)
Accessibility	3 (1)	3 (1)	6 (2)	6 (2)	**82 (28)**	100 (34)
Care safety	0 (0)	6 (2)	3 (1)	32 (11)	**59 (20)**	100 (34)
Providers' specializations	0 (0)	6 (2)	20 (7)	15 (5)	**59 (20)**	100 (34)
Providers' work experience	0 (0)	3 (1)	17 (6)	30 (10)	**50 (17)**	100 (34)
Care effectiveness	6 (2)	0 (0)	15 (5)	26 (9)	**53 (18)**	100 (34)
Customer reviews	3 (1)	0 (0)	29 (10)	27 (9)	**41 (14)**	100 (34)
Care efficiency	6(2)	3 (1)	17 (6)	33 (11)	**41 (14)**	100 (34)
Location	3 (1)	12 (4)	9 (3)	**41 (14)**	35 (12)	100 (34)
Opening hours	9 (3)	9 (3)	23.5 (8)	23.5 (8)	**35 (12)**	100 (34)
Providers' website	6 (2)	21 (7)	**26 (9)**	**26 (9)**	21 (7)	100 (34)
Pictures of premises	6 (2)	26 (9)	**32 (11)**	21 (7)	15 (5)	100 (34)
Providers' language skills	12 (4)	**44 (15)**	15 (5)	12 (4)	17 (6)	100 (34)
Providers' gender	**53 (18)**	17 (6)	15 (5)	6 (2)	9 (3)	100 (34)

Means have been calculated on the grading of each aspect (1=not at all important, 2=not very important, 3=fairly important, 4=important, 5=very important). These means are presented in table 31, listed in decreasing importance level.

Table 31: Descriptive statistics of information content variables

	n	Mean	Std. Deviation	Std. Error Mean
Accessibility	34	4.62	.954	.164
Care Safety	34	4.44	.824	.141
Specializations	34	4.26	.994	.171
Work Experience	34	4.26	.864	.148
Care effectiveness	34	4.21	1.095	.188
Reviews	34	4.03	1.000	.171
Care efficiency	34	4.00	1.128	.193
Location	34	3.94	1.099	.189
Opening hours	34	3.68	1.296	.222
Website	34	3.35	1.203	.206
Pictures of premises	34	3.12	1.149	.197
Language skills	34	2.79	1.321	.226
Gender therapist	34	2.00	1.326	.227

The highest mean (mean = 4.62) is reached for the information on accessibility of the premises. So it can be concluded that this is in general the most important information a customer wants to have when making a choice between physiotherapy service providers. Second most important is information on care or treatment safety. Next in line is information on providers' specializations and work experience. Next comes information on care or treatment effectiveness. After this respondents marked reviews from other customers as important. Next in descending order of importance comes information on care/treatment efficiency, location of the premises, opening hours, providers' website, pictures of premises and providers' language skills. The least important information for customers when making a choice between physiotherapy service providers is information on providers' gender (mean = 2.00).

9 Discussion

The literature study on how people choose, what information they value and how they use comparative information points in the direction that people may not make choices as rationally as policy-makers assume. Health care reforms in the UK and the Netherlands are for an important part based on the idea that, when offered sufficient, comparative, quality-related information about providers, customers will choose the provider

which offers the highest quality. This is believed to force providers to increase focus on quality, resulting in a health care system that is efficient, effective, equal and timely.

Benchmarking exercise and empirical study have offered evidence that increasing patient choice is a very valuable direction, full of possibilities, but also challenges.
Empirical data from this study prove that freedom of choice between health care service providers is important to severely disabled people in Finland, their family and carers and professionals helping them in their daily decisions. Even though no other surveys were found that focus on physiotherapy service providers, it can be stated that Finnish people share the same opinion on freedom of choice in health care with other European citizens. In a large scale research in the UK, Dixon, Robertson, Appleby, Burge, Devlin, Magee (2010) found that 75 % of the respondents find patient choice important or very important.
Coulter and Magee found in their search for the 'European patient of the future' (2003), that 92 % of respondents want to choose their primary care health provider.
Janlöv (2013) found that 77 % of patients in the Stockholm county in need of chronic care valued that freedom of choice, 75 % for Östergötland county and 75 % in Skåne county.

It seems that older people value the freedom of choice less than young people. Freedom of choice becomes decreasingly important with increasing age, but this could not be proven statistically. In their research, Coulter and Magee (2003), found evidence that younger people want to be more actively involved in their care and claim more freedom of choice between health care providers than older people. Coulter and Magee question whether this is a generational difference or whether people become more passive and less critical when getting older. They conclude it more likely that this is an actual cultural change where people become less and less content about passively receiving health care.
On the other hand, Dixon et al (2010) found in the UK that older people value the freedom of choice more than younger people.

An interesting trend was found when looking at differences between respondents with different educational backgrounds. People with a higher degree seem to value the freedom of choice between health care providers less than people without a degree or people with a vocational degree. Dixon et al (2010) come to a similar conclusion.

People with lower educational level valued the freedom of choice more than people with a degree. A similar slight decrease was mentioned by Coulter and Magee (2003) in choice of special care and hospitals by people holding a university degree compared to people with secondary and primary education.
This is an interesting trend, and it is not very easy to find an explanation. Coulter and Magee (2003) wonder if people with a university degree have an increased understanding of the disadvantages of choice or if they are more aware of the limited available information to support informed choice and if these are the reasons for being less active in choice. A more likely explanation may be that people with a higher education have more understanding of health care related matters and have therefore a better communication with health care professionals and a more satisfying relation with their doctors already. This is backed up by results from Coulter and Magee themselves (2003). Freedom of choice may not add as much value to these patients because they can already negotiate their wishes in their communication with their health care providers.

Enabling freedom of choice will not lead to its' supposed advantages for the customers and will not create better quality of care unless information on health care service providers is transparently available. To be able to create an efficient tool for sharing information, it is important to find out how satisfied people currently are with availability of information.
The results of this study show that half of the respondents have difficulties to find sufficient information on which a choice between providers could be made. About one third of the respondents claimed to have sufficient information. These numbers are quite similar to what Coulter and Magee found in 2003.

According to the findings in this study it seems that older people find information increasingly more difficult to find. This is not an observation that could be statistically confirmed. Coulter and Magee (2003) came to opposite results, with younger people less satisfied with the amount of available information. These results may not be as opposite as they at first seem. Older people are perhaps less capable of using sources such as the internet to their fullest potential and may therefore be left feeling like health related information is difficult to find. Younger people struggle less with this problem, but are more critical and may expect more information when making a choice between providers.

According to this study people with higher education find it more difficult to find sufficient information to make a choice between health care service providers. This may mean that people with a higher education expect more information to be able to make a choice and are less quickly satisfied.
Coulter and Magee (2003) found that people with higher education are more likely to say that they have enough information to make a choice between providers.
This discrepancy can partly be explained by the fact that this study is asking for information on physiotherapy service providers, whereas Coulter and Magee asked about information on doctors and hospitals.

Whether people are satisfied with available information or not, raises the question where people look for information. What sources do health care customers use and trust most? Half of the respondents of this study say they trust most in information provided by health care professionals when making a choice between physiotherapy service providers. One fourth of the respondents marked internet as most important source, making the internet second most important source for severely disabled patients and the people helping them in their decisions.
Coulter and Magee (2003) came to similar conclusions with 62 % of respondents marking health care professionals as most important source and 10 % internet.
Internet was only on fifth place in the listing of Coulter and Magee. It must be kept in mind that the study by Coulter and Magee (2003) was a European-wide survey and internet is not equally incorporated in daily life in all European countries. Additionally, the survey by Coulter and Magee was done almost 10 years ago. It can be assumed that internet has gradually gained ground as a source for information. But a recent research done in the Netherlands by Ketelaar, Faber, Westert, Elwyn and Braspenning (2014) pointed out that family and friends were mentioned as one of the most important sources of information in the choice between hospitals. Health care professionals were still mentioned by more respondents as a source than online comparative information tools. So even in a country where a multitude of information tools are available, these have not taken over the importance of other sources for information. As was mentioned in the literature study, Victoor et al (2012) had critical feedback to the Dutch policymakers after the introduction of patient choice. They indicated that not enough effort was put in promoting the freedom of choice and creating the awareness of the available information. This lack of effort possibly offers an explanation why online information tools have failed to become more trusted and used.

Interestingly, in this study older people seem to use internet more often than young people, but this could not be supported statistically.
Coulter and Magee (2003) found opposite results, where internet becomes decreasingly used with increasing age.
This also seems more logical, as younger people are more comfortable using internet. This is certainly something that should be studied on a larger scale.

Coulter and Magee (2003) had found that people with higher educational level favoured internet more than people with lower educational level. In this study the same trend was observed, though this could not be proven statistically.
This could be interpreted that people with a higher degree are more capable to understand health related information available online and trust their own interpretation and understanding of this information more.

In the light of this research it is interesting to find out whether people who look for information online are more satisfied than people who look for information from other sources.
The majority of respondents who look for information online are not happy with the available information. People who ask health care professionals for information are more satisfied.
These results indicate that there are difficulties with current online information. This survey did not include a question about what kind of difficulties people encounter when looking for information online, but Coulter and Magee (2003) asked their respondents to describe the problems faced when seeking health information. The majority of their respondents answered that the information available was difficult to understand. Other reasons were lack of information, conflicting information, distrust of available information or information that is too basic and insufficient.
As Faber and colleagues (2009) pointed out, in the decision-making process policymakers need to be aware of 4 stages, with awareness being the first stage.
People need to be aware of their freedom to choose, aware of the providers they can choose between and aware of the information tool. This awareness is a major condition for patient choice to lead to higher quality and cost containment of health care.
The missing link for the Kela information tool on rehabilitation providers for severely disabled people lays within this awareness. Choice is already possible for this patient group, there are enough choice options (1235 providers nationwide –autumn 2014), but there is no comparative information available yet.

When looking at what kind of information patients find most important when making a choice between physiotherapy service providers, information concerning accessibility of the premises is most important to the patient group in this study.
As the target group are severely disabled patients, this does not come as a surprise. If the premises are not easily accessible to them the information on the provider and the care are meaningless.
This result also gives a strong sign that information tools should be adjusted to specific patient groups. As pointed out by Victoor et al (2012), the needs and values of each patient group should be studied, and incorporated in a specific information tool.
In the benchmarking exercise only one information tool offered specific information for certain medical conditions. This tool is zorgkaartnederland.nl in the Netherlands. Each specific information path was created with the relevant patient organization.

Secondly important is information on quality of treatments and specific information on the quality of the provider. These findings are in line with the findings of Faber et al (2009).
They conclude that up to 50 % of people mention quality of care as their most important concern when selecting a provider. But Faber et al found out that in real-life experiments patients seemed to choose more based on trust, experience and the reputation of a provider, rather than on pure quality related indicators.
Boyce et al (2010) also concluded that experience and expertise of the individual service providers is marked as most important information in making a choice between hospitals. In the current study experience of the service provider comes on fourth place, so respondents do indeed value experience. Reputation as mentioned by Faber et al (2009) can be interpreted as reviews a provider receives from other consumers. This is an aspect that, in this study, came on sixth place. In their research on the effects of patient choice after the UK Health Care reform Dixon et al (2010) concluded that patient feedback seemed to be one of the main drivers for increased focus on quality of health care.
According to the findings in this study, the least important is info on gender and language skills. This proves that people in Finland trust that health care providers are capable of working in the main languages.

Research done abroad on the creation of information tools in health care and on how customers use this information has given some insight on how information should be presented and organized. Not to place too much, nor too technical information on one overview is important to avoid customers from being overwhelmed. The consistent use of clear signs and symbols makes an information tool easier to use and information more available for different patient groups.

Deep-linking is used for those patients that require more information, for example people with higher education. Providers should be aware of avoiding contradictory information or missing data, as this creates a feeling of distrust among the customers.

When bringing the results from the benchmarking exercise and the pilot study together with knowledge on the complex processes behind decision-making, it becomes clear that the creation of an information tool is not a straight-forward, one-fits-all kind of endeavour. Scientific research on the creation process of information tools, on how the information tool is used and whether an information tool truly improves the quality of choices is necessary. For this to be possible, measures of decision quality must be established. For example, The Foundation for Informed Medical Decision Making (FIMDM) is supporting research into the development of decision-specific instruments to measure decision quality across multiple domains.

Figure 23 gives an idea of the optimal incorporation of patient choice, and shows how information tools could continue to be developed and adapted according to decisions being made based on these tools.

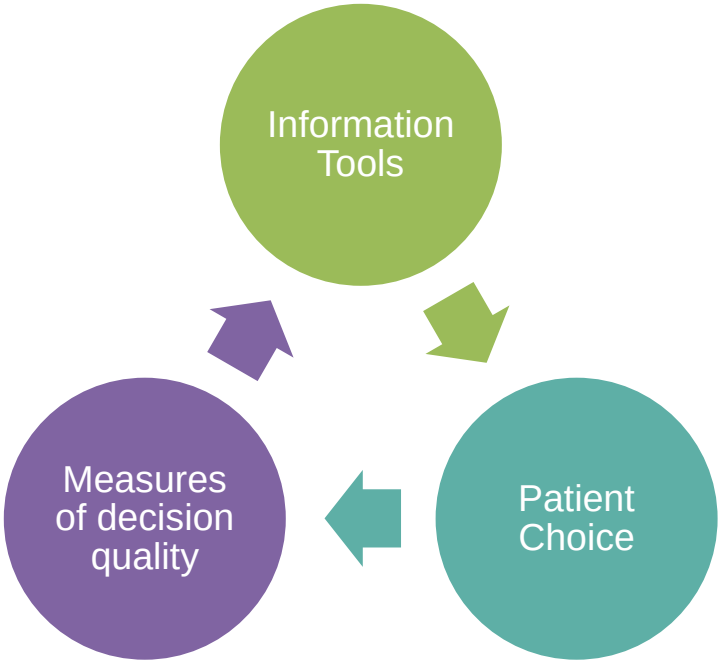

Figure 23. Optimal incorporation of information tools

Another important matter is that relevant information as seen by professionals is different from relevant information as seen by customers. This enforces that the best approach for creating high-quality information tools is co-creation with the specific patient groups.

It is equally important to keep in mind that a system where patients are active customers may benefit only those people who are willing and capable of making informed choices, mainly the younger, well-educated people (Boyce et al, 2010). So a critical evaluation and follow-up is necessary.

10 Conclusions

The Finnish Health Care Act of 2010 has started the process of empowering the Finnish patient. Increasing freedom of choice between health care service providers is a major part of this empowerment. When customers are free to choose between providers, this will increase competition, and this competition is believed to create a strong incentive for increased focus on quality among providers. So, aside from the benefits for the customers, patient choice is also a tool to reach a more qualitative, accessible, timely, safe and efficient health care system.

The Finnish Social Insurance Institution (Kela) is already offering freedom of choice between rehabilitation service providers to severely disabled people. However, freedom of choice will never lead to the believed benefits unless there is a system in place that ensures the provision of adequate, sufficient, accessible and comparative information on each provider. At this moment there is no such system in Finland and very little research has been done on the topic of patient choice and the process behind it.

This study aimed to find out how severely disabled people value freedom of choice between physiotherapy service providers and what kind of information this patient group needs and values to enable patient choice. Through the webpages and Facebook pages of relevant patient organizations severely disabled people and the people helping them in their decisions were encouraged to fill out an online questionnaire. Results were analysed quantitatively using non-parametric statistics.

The sample was small, which limits the possibility to generalize the results to the entire population of severely disabled people, but this study offers nevertheless valuable information and highlights the necessity for future research.

The results from the empirical study provide evidence of the importance of an information tool geared towards this specific patient group and reveal what kind of information this tool should contain.
Severely disabled people and the people helping them with their decisions value the freedom of choice, but are not satisfied with the information currently available on each option. One fourth of the customers look for information online, but are less satisfied with this information than customers asking health care professionals.
A large section of the questionnaire was created to allow mapping of the specific information needs of this patient groups.

Through a benchmarking exercise between the Netherlands, the UK and Finland knowledge was gathered on lay-out and creation process of information tools. The history, organization and funding of health care systems in these countries show similarities which allow for meaningful benchmarking. In the Netherlands and the UK patient choice has been longer and more actively promoted and researched.

Based on the results from the benchmarking exercise, characteristics of a 'functional information tool' can be described.

1. The information content must be built from specific needs of the patient group. This implies that each patient group would have 'own' information tools, or at least 'own' information paths within the same tool. Patient organizations could play an important role in the creation of these specific tools or paths.
2. Co-creation of the information by the customers, providers and policy-makers. Customers offer feedback on services, providers offer factual information and policy-makers collect objective quality information on the services.
3. Preference nudges can be used before starting the actual information search to help customers focus on their values. This will increase the chances of choosing a provider based on these needs and values.
4. Good website design is important with clear overviews, avoiding too much information. Possibility of deep-linking for those customers that want more information.
5. Clear, easy-to-understand language and consistent use of symbols.

6. Grouping of quality indicators.
7. When possible, avoid missing or contradictory data.
8. Follow-up of decision quality is needed once the tool is operational.

Policy-makers must be aware of the necessity to actively promote freedom of choice and create a strong awareness of this freedom and of the available information.
Policy-makers should equally understand that not each patient group may be equally willing or able to choose. To avoid jeopardizing the equal access of health care, the needs of each patient group must be studied.

For sharing of information, increased patient choice and transparency to lead to a health care system of higher quality, efficiency, responsiveness, accountability and equity, a customer-centred model and a continuous interaction between customers, providers and policy-makers is necessary.
The benchmarking exercise brought examples of information tools where the benefits of policy-makers or the benefits of the providers were placed above the benefits of the customers, and this is a scenario that must be avoided.
There were also a few warnings that came up through the literature study: customers may use only a fraction of the information presented in the tools, and may not choose the provider of the highest quality as expected by policy-makers.

These warnings strengthen the urge for more research. An increased understanding of how customers use information tools and how people make choices is needed. This study is one of the first studies on patient choice in Finland. There are numerous opportunities for future research. The same research questions should be tested on a larger sample of this same patient group, so that stronger conclusions could be drawn. The same research questions need to be studied for other patient groups and other types of health care service providers.
More research is also needed on how Finnish people use health care related, comparative information tools and how these tools improve decision quality. For this to be possible, measures of decision quality must be established.

The process towards a customer-centric, qualitative, efficient, responsive and equally accessible health care is complex but intriguing, with health care customers, providers

and policy makers needed in constant communication and interaction. This study is an important step in enlightening this process.

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E-lomake kysely

Asiakkaan valinta Kelan vaikeavammaisten avomuotoisissa fysioterapiapalveluissa. Mitä tietoa tarvitsen, kun valitsen avoterapiapalveluiden tuottajan?

Hyvä Vastaanottaja,

Kansaneläkelaitos (Kela) järjestää vaikeavammaisten avoterapiapalveluita, joissa on käytössä asiakkaan valinta. Tässä kyselyssä selvitetään, millaista tietoa koette tarvitsevanne palveluntuottajista, kun teette palveluvalintoja Kelan vaikeavammaisten avomuotoisen fysioterapian asiakkaana,omaisena tai muutoin hoidosta vastaavana henkilönä.

Olen fysioterapeutti Anneleen Burmansson ja suoritan kyselytutkimuksen osana Metropolian ammattikorkeakoulun Health Business Management korkeakouluopintojani (YAMK). Tutkimus tehdään yhteistyössä Kansaneläkelaitoksen (Kela) kanssa ja selvityksen tavoitteena on kartoittaa niitä palveluntuottajia ja palvelun sisältöä kuvaavia tekijöitä joita asiakkaat tarvitsevat tehdessään päätöksiä palveluntuottajien välillä.

Jos olet Kelan vaikeavammaisille kohdistetun avomuotoisen fysioterapian palveluiden käyttäjä, omainen tai hoitavan tahon edustaja, olisi ensiarvoisen tärkeää jos pystyisitte vastaamaan liitteenä olevaan kyselyyn. Vastaaminen on täysin vapaaehtoista ja arvostan suuresti vaivannäköänne.

Kyselyyn vastaaminen kestää noin 5 minuuttia. Vastaukset käsitellään ja raportoidaan huolellisesti ja luottamuksellisesti niin, etteivät vastaajien yksilölliset tiedot tule esiin. Henkilötietoja kyselyssä ei kysytä. Valmis tutkimustyöni toimitetaan Kelan käyttöön sekä niille potilasjärjestöille, joiden internetsivuilla tämä kysely on julkaistu. Metropolian hyväksytyt opinnäytetyöt ovat nähtävissä ja avoimesti saatavilla osoitteessa www.theseus.fi .

Kiitos vaivannäöstänne! Mielipiteenne on hyvin tärkeä ja vastaamalla voitte vaikuttaa asiakkaan valintaan liittyvien tietosisältöjen kehittämiseen.

Vastaan mielelläni mahdollisiin lisäkysymyksiin joko puhelimitse tai sähköpostitse.

Ystävällisin terveisin,

Anneleen Burmansson – Anneleen.Burmansson@metropolia.fi

Vastaajan henkilötiedot

* Ikä (vuotta) ?

* Sukupuoli
--Valitse tästä--

* Asuinkunta ?

Olet
- [ ] potilas / kuntoutuja
- [ ] potilaan / kuntoutujan omainen
- [ ] hoitava taho
- [ ] muu

Jos vastasit yllä olevaan kysymykseen muu
Tarkenna
mikä?

Koulutuksesi ?
- [ ] Peruskoulu
- [ ] Lukio
- [ ] Toisenasteen tutkinto (ammattikoulu)
- [ ] Korkeakoulutukinto (ammattikorkeakoulu tai yliopisto)
- [ ] Ylempi korkeakoulututkinto

Miten arviosit seuraavia asiakkaan valintaan ja terveydenhuollon palveluntuottajiin liittyviä väitteitä?

* Mahdollisuus valita terveydenhuollon palveluntuottaja on minulle tärkeää.
--Valitse tästä--

* Terveydenhuollon palveluntuottajista on minusta helppoa löytää riittävästi tietoa parhaan mahdollisen valinnan tekemiseen.
--Valitse tästä--

Arvioi, mistä tai keneltä löydät parhaiten tietoa palveluntuottajista:
- [ ] Terveydenhoidon ammattilaisilta
- [ ] Kelalta
- [ ] Ystäviltä / Sukulaisilta
- [ ] Mainoksista
- [ ] Internetistä
- [ ] Potilasjärjestöiltä
- [ ] Muualta

Jos vastasit yllä olevaan kysymykseen muualta
Tarkenna
Mistä?

Arvioi kuinka tärkeänä pidätte seuraavia asioita palveluntuottajista?

* Palveluntuottajan sijainti? ?
--Valitse tästä--

* Esteetön pääsy palveluntuottajan tiloihin?
--Valitse tästä--

* Tietoja palveluntuottajan aukioloajoista?
--Valitse tästä--

* Palveluntuottajan www-sivustot?
--Valitse tästä--

* Kuvia palveluntuottajan tiloista?
--Valitse tästä--

* Tietoja palveluntuottajan kielitaidosta? ?
--Valitse tästä--

* Tietoja palveluntuottajan erikoistumista? ?
--Valitse tästä--

* Tietoja palveluntuottajan työkokemuksesta ?
--Valitse tästä--

* Tietoja palvelun / hoidon tehokkuudesta?
--Valitse tästä--

* Tietoja palvelun / hoidon vaikuttavuudesta?
--Valitse tästä--

* Tietoja palvelun / hoidon turvallisuudesta?
--Valitse tästä--

* Kuinka tärkeänä pidätte ihmisten kokemuksiin perustuvia arvioita palveluntuottajasta?
--Valitse tästä--

* Kuinka tärkeänä pidätte tuottajan sukupuolta?
--Valitse tästä--

Mitä muuta tietoa voisitte tarvita tehdäksenne valinnan palveluntuottajien välillä?
Tarkenna
Mitä?

Tietojen lähetys

Tallenna

Advanced search results through Easiointi.kela

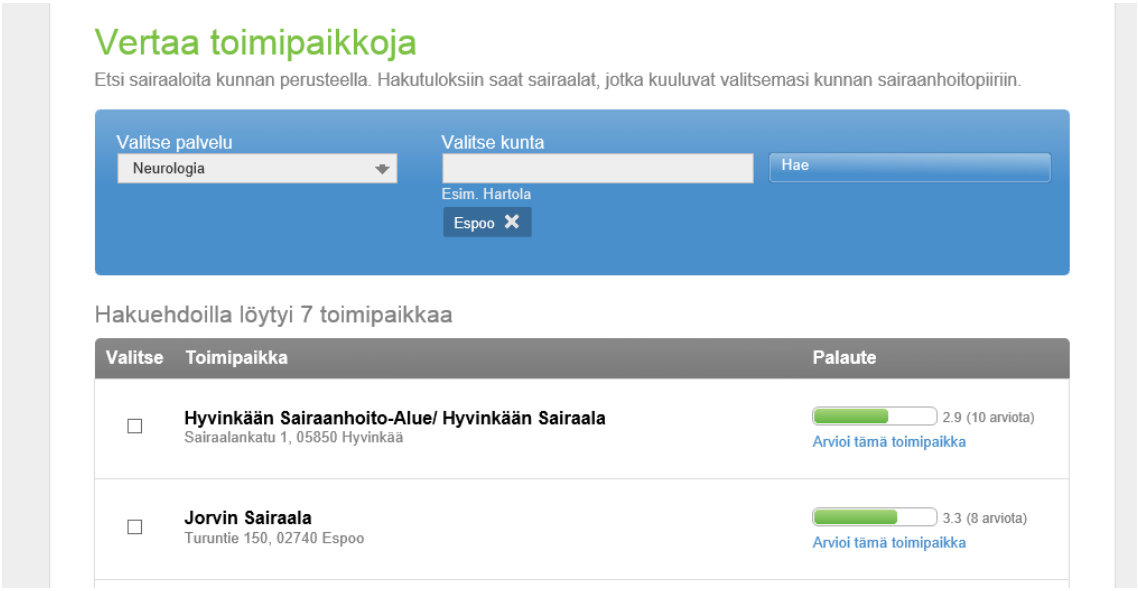
Kela

Kuntoutuksen palveluntuottajat

Valitsemasi hakutekijät: vaikeavammaisten lääkinnällinen kuntoutus, fysioterapia, kielitaito suomi
Hakutulos: 1241 palveluntuottajaa

Palveluntuottajan nimi	Toimipisteen sijainti	Puhelin	www-sivut / sähköposti
10-Fysio Avoin Yhtiö	Vesijärvenkatu 8 15100 LAHTI	040 768 5136, 03 7522 296	http://www.10-fysio.fi ftteravainen@gmail.com
A-Fysioterapia Oy	Malmin kauppatie 18 00700 HELSINKI	09 3855575	http://www.a-fysioterapia.fi a@a-fysioterapia.fi
Active Rehab Kb/Carina Nyholm	Pellervogatan 12 65300 VAASA	06 3159030, 040 5968863	carina@activerehab.fi
Activus Ky, lasten ja nuorten terapiakeskus	Verkatehtaankatu 4, 5.krs 20100 TURKU	02 2515215, 050 5402434	http://www.activus.fi info@activus.fi
Af Heurlin Dagrun	Ei toimitiloja	0400636258	dagrun51@gmail.com
Ahtola Sirpa Helena	Läntinen Pitkäkatu 21-23 D 20100 TURKU	02 251 3420, 040 7286107	http://www.valiofysio.fi sirppis@dnainternet.net
Airan fysioterapia, Aira Korhonen	Pohjolankatu 21 87100 KAJAANI	08 627353, 050 3533625	http://www.kainuu.com/axilla axilla.aira@kajaani.net
Aivoliitto ry	Suvilinnantie 2 20900 TURKU	02 2138200	http://www.aivoliitto.fi info@aivoliitto.fi
Ajan Terapia Oy	Rummunlyöjänkatu 14 B 1 24100 SALO	02 733 7772, 02 7316 242	hillevi.ajalin@ebaana.net
Aktiiviterapia OY	Mikkolantie 1-3 33470 YLÖJÄRVI	0500625037, 050 3364482	http://www.aktiiviterapia.fi h.martikainen@suomi24.fi

Advanced search results through Palveluvaaka.fi



Vertaa toimipaikkoja

Etsi sairaaloita kunnan perusteella. Hakutuloksiin saat sairaalat, jotka kuuluvat valitsemasi kunnan sairaanhoitopiiriin.

Valitse palvelu: Neurologia

Valitse kunta: Espoo

Hae

VAIKUTTAVUUS	Hyvinkään Sairaanhoito-Alue/ Hyvinkään Sairaala	Jorvin Sairaala
Niiden aivoinfarktipotilaiden osuus, jotka ovat 30 päivän jälkeen elossa Mitä tämä luku tarkoittaa?	Tietoa ei ole saatavilla	92.2 % Päivitetty 2007-2009

Hakuehdoilla löytyi 7 toimipaikkaa

- Porvoon Sairaanhoitoalue / Porvoon Sairaala
- Lohjan Sairaanhoitoalue/ Lohjan Sairaala
- Västra Nylands Sjukvårdsområde / Västra Nylands Sjukhus
- Hyvinkään Sairaanhoito-Alue/ Hyvinkään Sairaala
- Jorvin Sairaala
- Peijaksen Sairaala
- Meilahden Sairaala / Hus-Kirurgian Klinikka

Sairaalakohtainen vertailutieto

Huomaa, että pääkaupunkiseudun sairaalat kuuluvat HYKS-sairaanhoitoalueeseen.

VAIKUTTAVUUS	Hyvinkään Sairaala	Hyks-Sairaanhoitoalue
Niiden aivoinfarktipotilaiden osuus, jotka ovat 30 päivän jälkeen elossa Mitä tämä luku tarkoittaa?	93.1 % Päivitetty 2007-2009	92.0 % Päivitetty 2007-2009

Sairaanhoitopiirikohtainen vertailutieto

Tieto on saatavissa siitä sairaanhoitopiiristä, johon valitsemasi sairaala kuuluu. Huomaa, että vertailuun valitsemasi sairaalat voivat kuulua samaan sairaanhoitopiiriin.

Valitse toimipaikat

HOIDON SAANTI	Helsingin ja Uudenmaan sairaanhoitopiiri	Helsingin ja Uudenmaan sairaanhoitopiiri
Lähetteen käsittelyaika Mitä tämä luku tarkoittaa?	4.0 vrk Päivitetty 31.12.2012	4.0 vrk Päivitetty 31.12.2012
Odotusaika ensimmäiselle käynnille alle 3 kuukautta Mitä tämä luku tarkoittaa?	100.0 % Päivitetty 31.12.2012	100.0 % Päivitetty 31.12.2012
Keskimääräinen odotusaika ensimmäiselle käynnille Mitä tämä luku tarkoittaa?	29.0 vrk Päivitetty 31.12.2012	29.0 vrk Päivitetty 31.12.2012
Alle 6 kuukautta hoitoa, leikkausta tai toimenpidettä odottaneet Mitä tämä luku tarkoittaa?	100.0 % Päivitetty 31.12.2012	100.0 % Päivitetty 31.12.2012
Leikkauksen, toimenpiteen tai hoidon odotusaika Mitä tämä luku tarkoittaa?	60.0 vrk Päivitetty 31.12.2012	60.0 vrk Päivitetty 31.12.2012

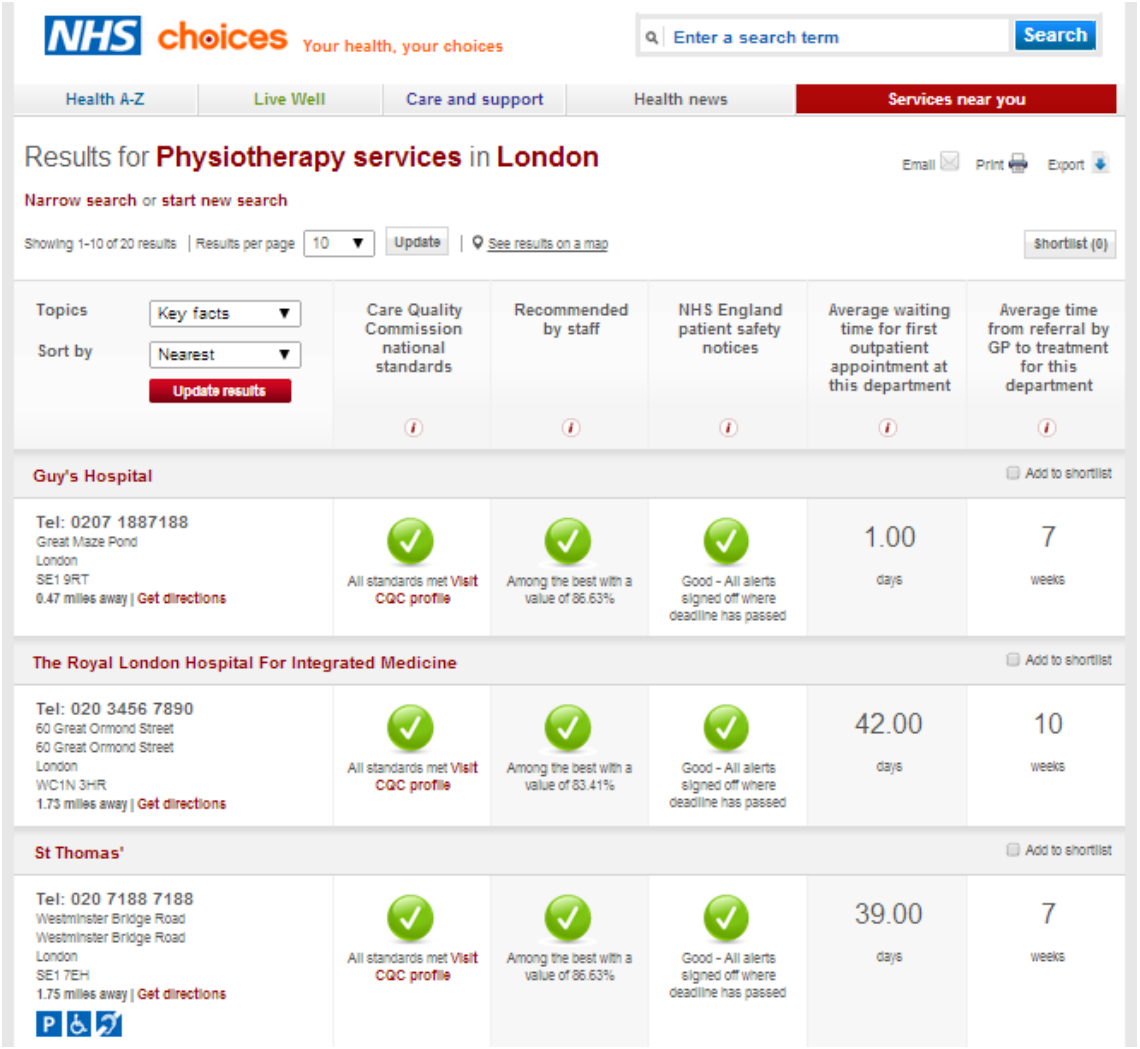
Käyttäjäpalaute

Valitsemistasi toimipaikoista Palveluvaaka.fi:ssä annetut arviot.

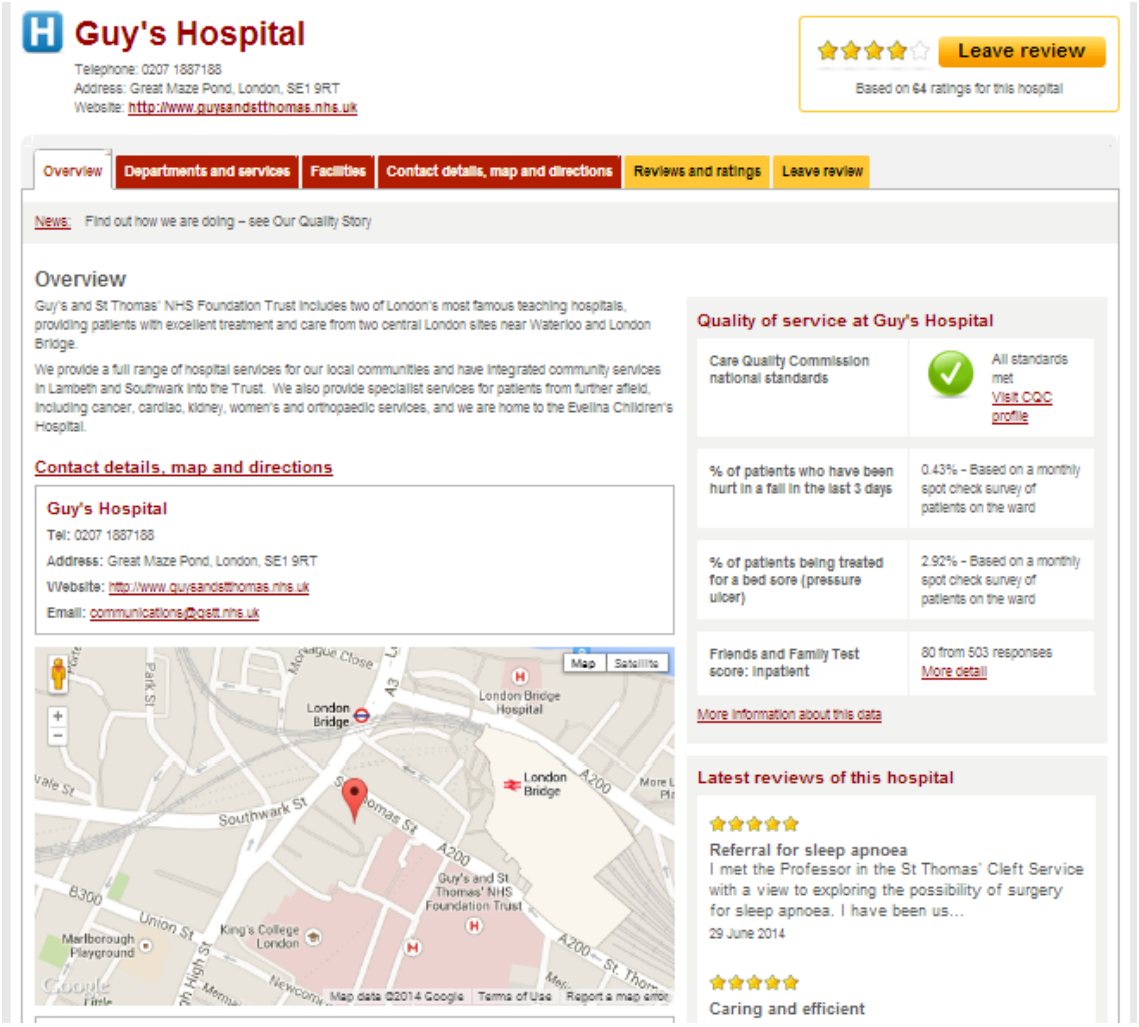
KÄYTTÄJÄPALAUTE	Jorvin Sairaala	Hyvinkään Sairaanhoito-Alue/ Hyvinkään Sairaala
Pääsin hoitoon / palveluun riittävän nopeasti	3.0 8 arviota	2.3 10 arviota
Odotusajan pituus paikanpäällä oli kohtuullinen saapumisesta siihen, kunnes minua palveltiin	3.4 8 arviota	2.5 10 arviota
Henkilökunnalla oli riittävästi aikaa minulle	2.9 8 arviota	2.7 10 arviota
Sain riittävästi tietoa ja neuvontaa	3.0 8 arviota	2.7 10 arviota
Asioitani käsiteltiin luottamuksellisesti ja yksityisyyteni säilyttäen	3.8 8 arviota	3.5 10 arviota
Sain osallistua hoitoani / palveluani koskevaan päätöksentekoon	3.1 8 arviota	3.0 10 arviota
Hoito- / palvelutapahtuma oli sujuva	3.4 8 arviota	2.9 10 arviota
Hoidon / palvelun hinta oli minulle kohtuullinen	4.5 8 arviota	3.8 10 arviota
Tilat olivat viihtyisiä, toimivia ja siistejä	3.5 8 arviota	3.0 10 arviota
Hoito / palvelu vastasi tarpeitani	2.9 8 arviota	2.7 10 arviota

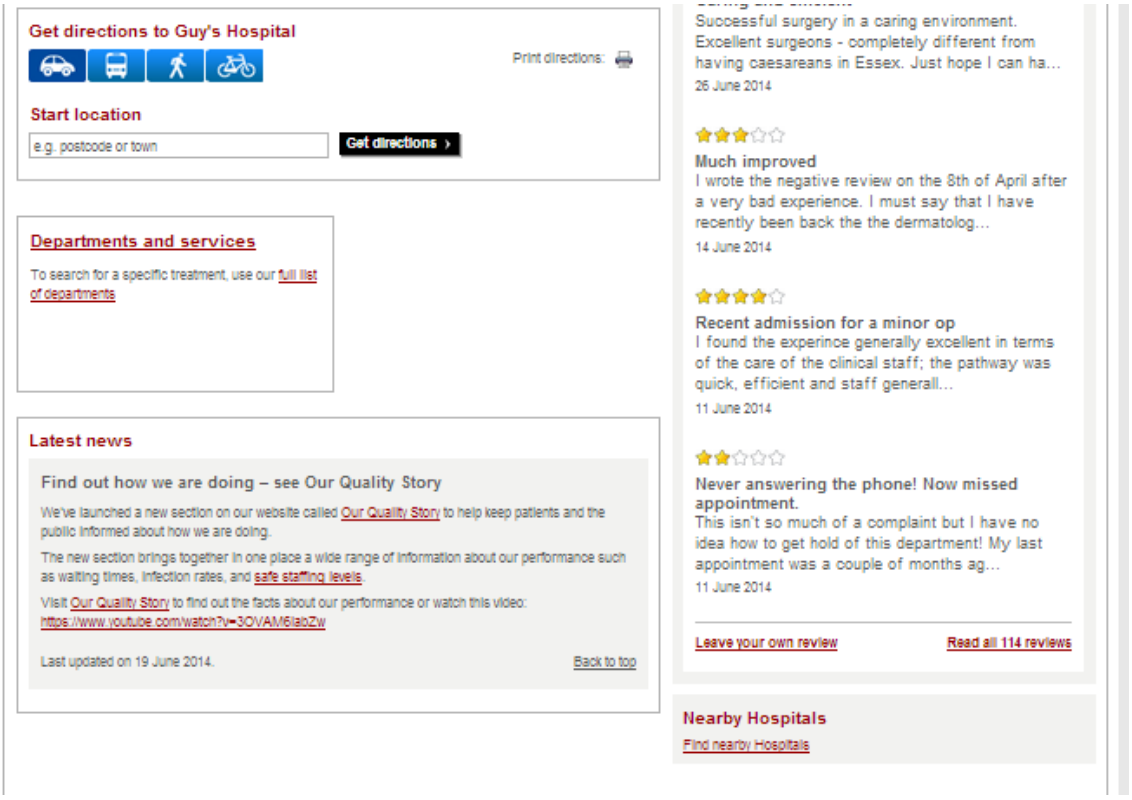
Advanced search results through choose and book.

Overview of all hospitals:



Starting page with overview and other sections for hospital selection:





Get directions to Guy's Hospital

Print directions:

Start location

e.g. postcode or town

Get directions ›

Departments and services

To search for a specific treatment, use our full list of departments

Latest news

Find out how we are doing – see Our Quality Story

We've launched a new section on our website called Our Quality Story to help keep patients and the public informed about how we are doing.

The new section brings together in one place a wide range of information about our performance such as waiting times, infection rates, and safe staffing levels.

Visit Our Quality Story to find out the facts about our performance or watch this video: https://www.youtube.com/watch?v=3OVAM6IaIbZw

Last updated on 19 June 2014. Back to top

Successful surgery in a caring environment. Excellent surgeons - completely different from having caesareans in Essex. Just hope I can ha...
26 June 2014

Much improved
I wrote the negative review on the 8th of April after a very bad experience. I must say that I have recently been back the the dermatolog...
14 June 2014

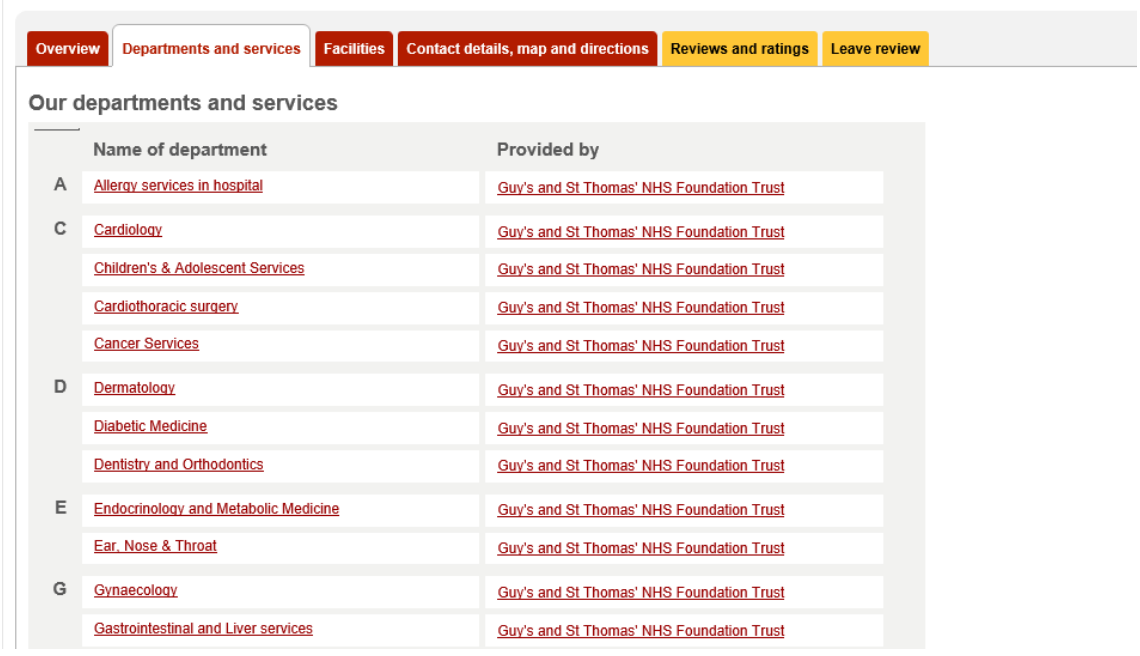
Recent admission for a minor op
I found the experince generally excellent in terms of the care of the clinical staff; the pathway was quick, efficient and staff generall...
11 June 2014

Never answering the phone! Now missed appointment.
This isn't so much of a complaint but I have no idea how to get hold of this department! My last appointment was a couple of months ag...
11 June 2014

Leave your own review Read all 114 reviews

Nearby Hospitals

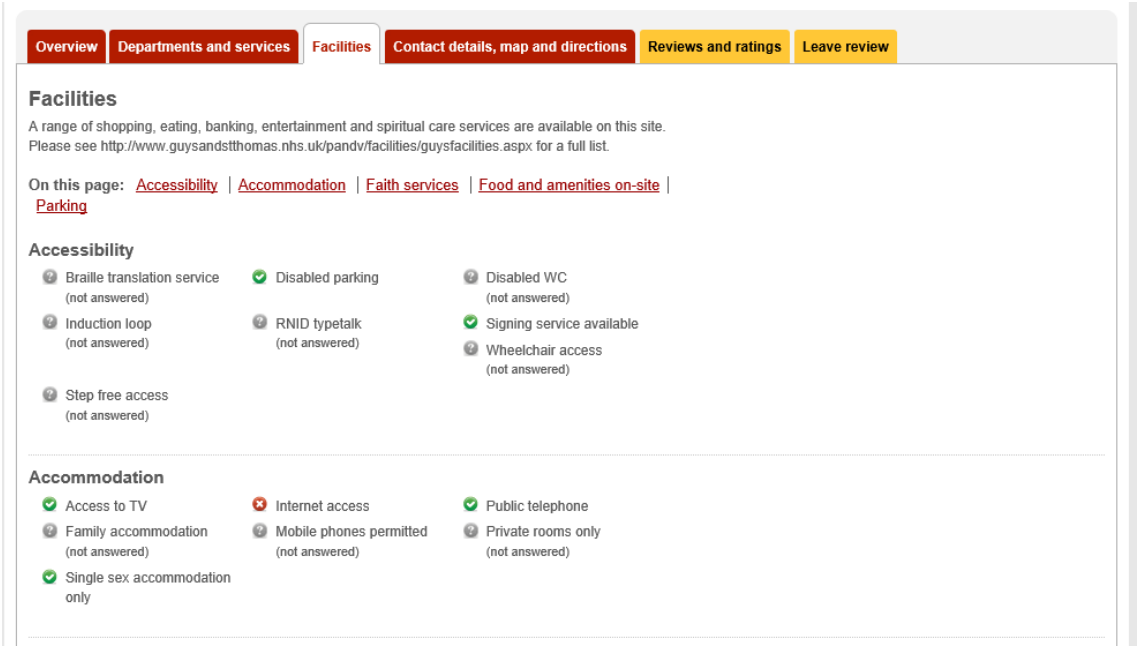
Find nearby Hospitals



Overview | Departments and services | Facilities | Contact details, map and directions | Reviews and ratings | Leave review

Our departments and services

	Name of department	Provided by
A	Allergy services in hospital	Guy's and St Thomas' NHS Foundation Trust
C	Cardiology	Guy's and St Thomas' NHS Foundation Trust
	Children's & Adolescent Services	Guy's and St Thomas' NHS Foundation Trust
	Cardiothoracic surgery	Guy's and St Thomas' NHS Foundation Trust
	Cancer Services	Guy's and St Thomas' NHS Foundation Trust
D	Dermatology	Guy's and St Thomas' NHS Foundation Trust
	Diabetic Medicine	Guy's and St Thomas' NHS Foundation Trust
	Dentistry and Orthodontics	Guy's and St Thomas' NHS Foundation Trust
E	Endocrinology and Metabolic Medicine	Guy's and St Thomas' NHS Foundation Trust
	Ear, Nose & Throat	Guy's and St Thomas' NHS Foundation Trust
G	Gynaecology	Guy's and St Thomas' NHS Foundation Trust
	Gastrointestinal and Liver services	Guy's and St Thomas' NHS Foundation Trust



Overview | Departments and services | Facilities | Contact details, map and directions | Reviews and ratings | Leave review

Facilities

A range of shopping, eating, banking, entertainment and spiritual care services are available on this site. Please see http://www.guysandstthomas.nhs.uk/pandv/facilities/guysfacilities.aspx for a full list.

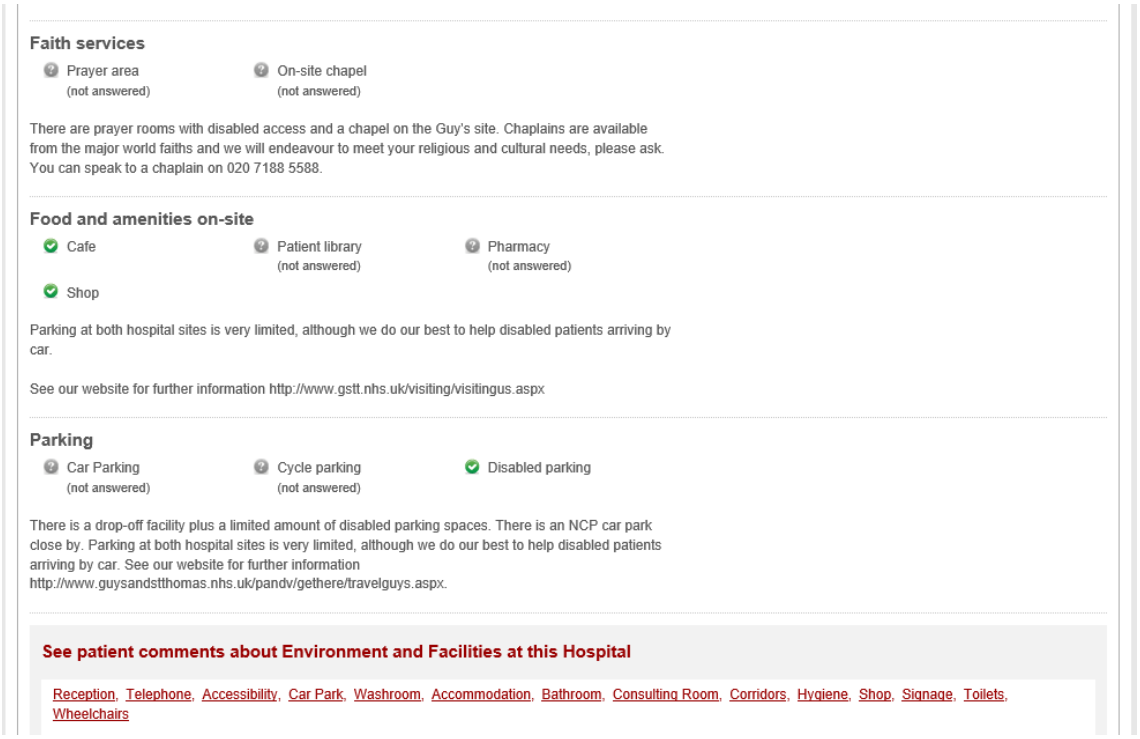
On this page: Accessibility | Accommodation | Faith services | Food and amenities on-site | Parking

Accessibility

- Braille translation service (not answered)
- Disabled parking
- Disabled WC (not answered)
- Induction loop (not answered)
- RNID typetalk (not answered)
- Signing service available
- Wheelchair access (not answered)
- Step free access (not answered)

Accommodation

- Access to TV
- Internet access
- Public telephone
- Family accommodation (not answered)
- Mobile phones permitted (not answered)
- Private rooms only (not answered)
- Single sex accommodation only



Faith services

- Prayer area (not answered)
- On-site chapel (not answered)

There are prayer rooms with disabled access and a chapel on the Guy's site. Chaplains are available from the major world faiths and we will endeavour to meet your religious and cultural needs, please ask. You can speak to a chaplain on 020 7188 5588.

Food and amenities on-site

- Cafe
- Patient library (not answered)
- Pharmacy (not answered)
- Shop

Parking at both hospital sites is very limited, although we do our best to help disabled patients arriving by car.

See our website for further information http://www.gstt.nhs.uk/visiting/visitingus.aspx

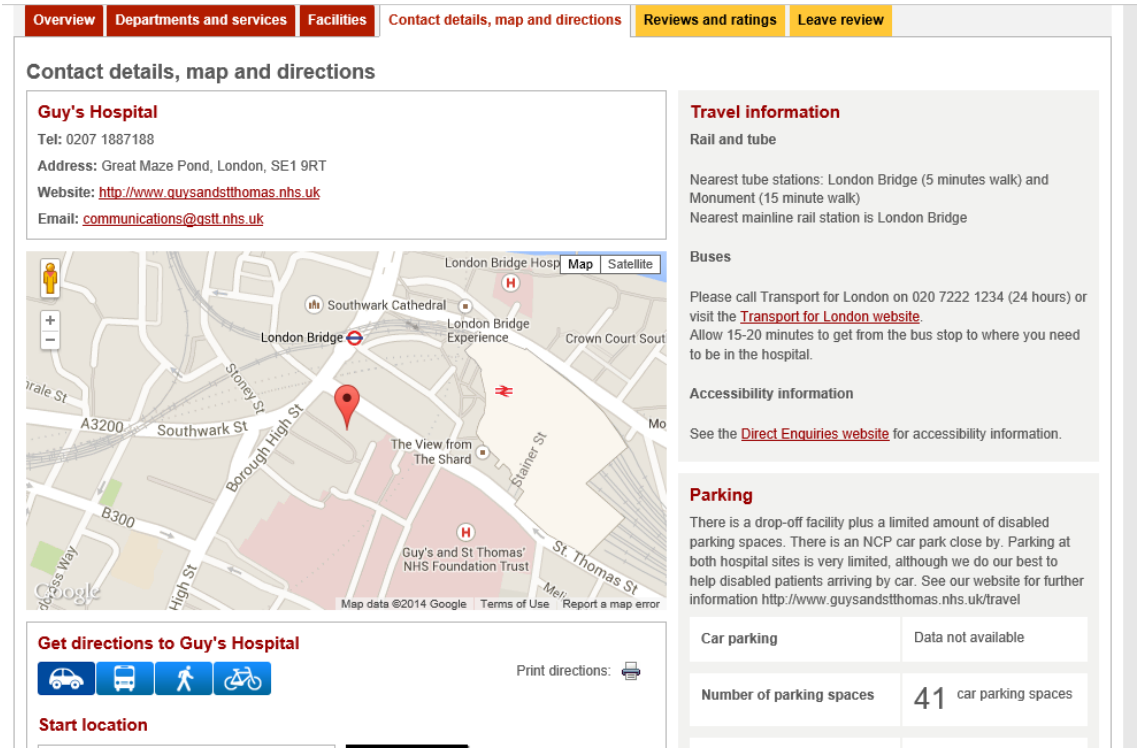
Parking

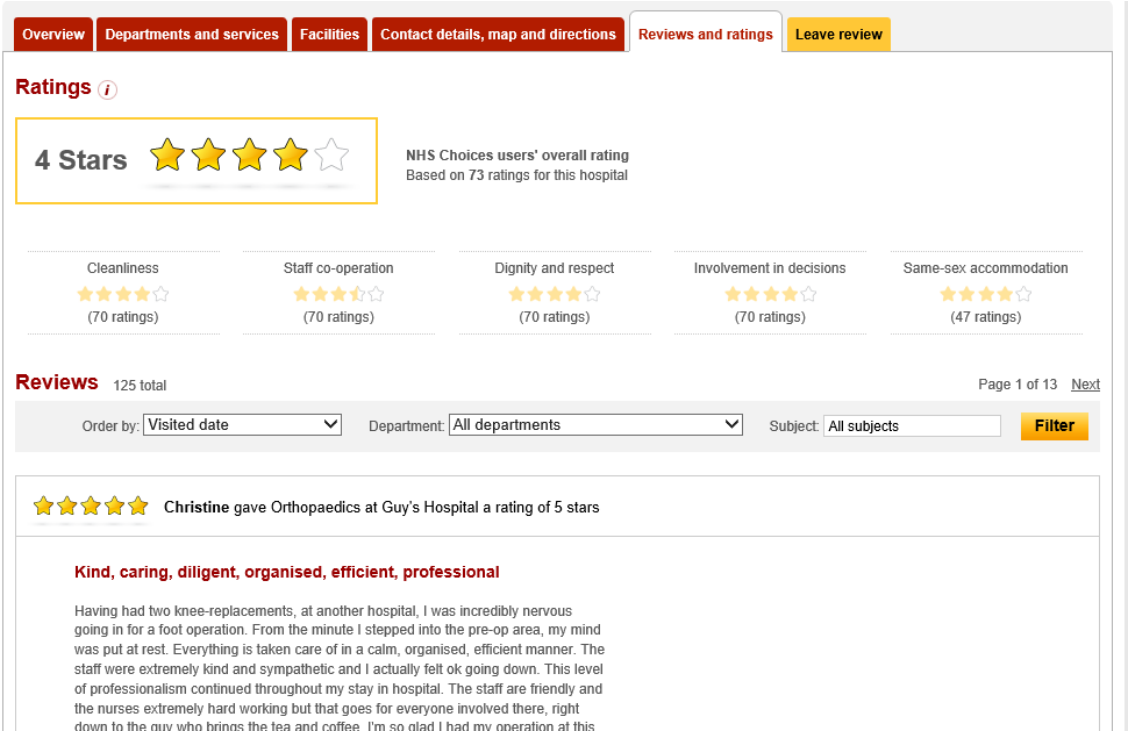
- Car Parking (not answered)
- Cycle parking (not answered)
- Disabled parking

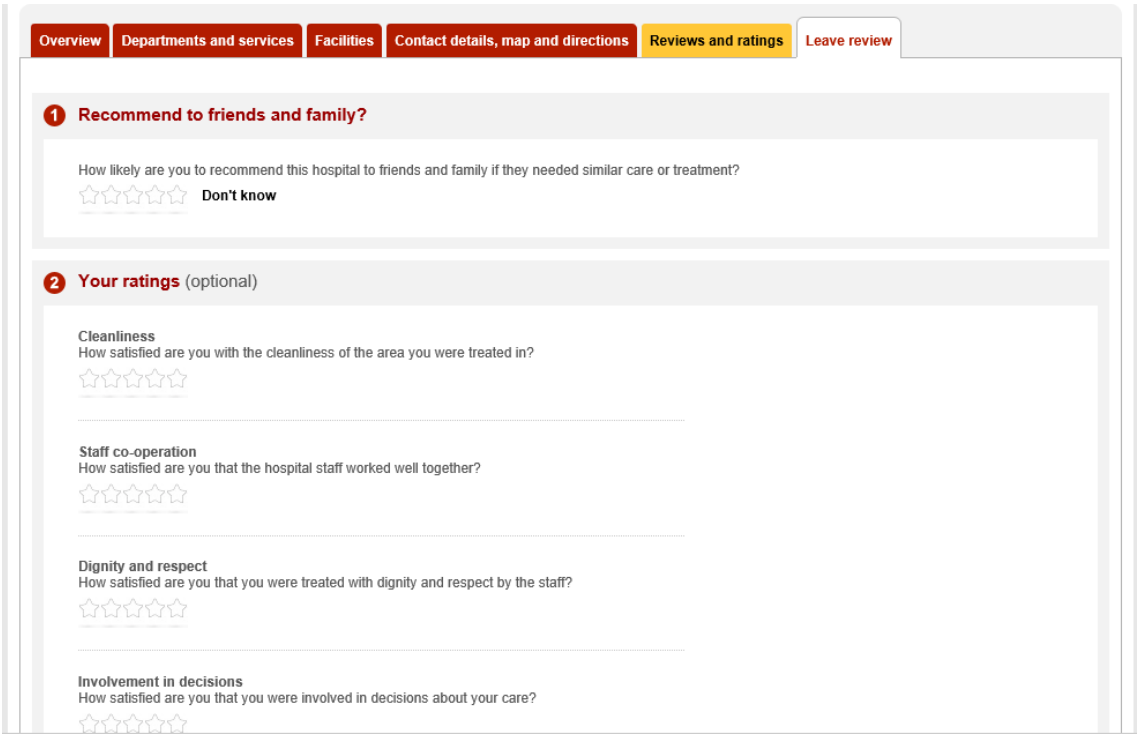
There is a drop-off facility plus a limited amount of disabled parking spaces. There is an NCP car park close by. Parking at both hospital sites is very limited, although we do our best to help disabled patients arriving by car. See our website for further information http://www.guysandstthomas.nhs.uk/pandv/gethere/travelguys.aspx.

See patient comments about Environment and Facilities at this Hospital

Reception, Telephone, Accessibility, Car Park, Washroom, Accommodation, Bathroom, Consulting Room, Corridors, Hygiene, Shop, Signage, Toilets, Wheelchairs


Overview
Departments and services
Facilities
Contact details, map and directions
Reviews and ratings
Leave review
Contact details, map and directions
Guy's Hospital
Tel: 0207 1887188
Address: Great Maze Pond, London, SE1 9RT
Website: http://www.guysandstthomas.nhs.uk
Email: communications@gstt.nhs.uk
Travel information
Rail and tube
Nearest tube stations: London Bridge (5 minutes walk) and Monument (15 minute walk)
Nearest mainline rail station is London Bridge
Buses
Please call Transport for London on 020 7222 1234 (24 hours) or visit the Transport for London website.
Allow 15-20 minutes to get from the bus stop to where you need to be in the hospital.
Accessibility information
See the Direct Enquiries website for accessibility information.
Parking
There is a drop-off facility plus a limited amount of disabled parking spaces. There is an NCP car park close by. Parking at both hospital sites is very limited, although we do our best to help disabled patients arriving by car. See our website for further information http://www.guysandstthomas.nhs.uk/travel
Car parking
Data not available
Number of parking spaces
41
car parking spaces
Map
Satellite
London Bridge Hosp
Southwark Cathedral
London Bridge
London Bridge Experience
Crown Court Sout
Stoney St
Southwark St
A3200
Borough High St
The View from The Shard
Stainer St
B300
Guy's and St Thomas' NHS Foundation Trust
St. Thomas St
High St
Map data ©2014 Google
Terms of Use
Report a map error
Get directions to Guy's Hospital
Print directions:
Start location


Overview
Departments and services
Facilities
Contact details, map and directions
Reviews and ratings
Leave review
Ratings
4 Stars
NHS Choices users' overall rating
Based on 73 ratings for this hospital
Cleanliness
(70 ratings)
Staff co-operation
(70 ratings)
Dignity and respect
(70 ratings)
Involvement in decisions
(70 ratings)
Same-sex accommodation
(47 ratings)
Reviews
125 total
Page 1 of 13
Next
Order by: Visited date
Department: All departments
Subject: All subjects
Filter
Christine gave Orthopaedics at Guy's Hospital a rating of 5 stars
Kind, caring, diligent, organised, efficient, professional
Having had two knee-replacements, at another hospital, I was incredibly nervous going in for a foot operation. From the minute I stepped into the pre-op area, my mind was put at rest. Everything is taken care of in a calm, organised, efficient manner. The staff were extremely kind and sympathetic and I actually felt ok going down. This level of professionalism continued throughout my stay in hospital. The staff are friendly and the nurses extremely hard working but that goes for everyone involved there, right down to the guy who brings the tea and coffee. I'm so glad I had my operation at this


Overview
Departments and services
Facilities
Contact details, map and directions
Reviews and ratings
Leave review
1 Recommend to friends and family?
How likely are you to recommend this hospital to friends and family if they needed similar care or treatment?
Don't know
2 Your ratings (optional)
Cleanliness
How satisfied are you with the cleanliness of the area you were treated in?
Staff co-operation
How satisfied are you that the hospital staff worked well together?
Dignity and respect
How satisfied are you that you were treated with dignity and respect by the staff?
Involvement in decisions
How satisfied are you that you were involved in decisions about your care?

Advanced search results through Physio2U.

Your postcode | Amputee rehabilitation | No payment preference

SUBMIT

Sponsored results

Title	Address	Hours	Distance	Payment options
Optimal Rehab Delivering Neurological Physiotherapy & Occupational Therapy	Cheshire, Staffordshire, South M/cr-Home visits 26 Needham Drive, Cranage Holmes Chapel Crewe CW4 8FB	Flexible - Mon-Fri + weekends, Home visits & clinics		Private
Ankerside Physiotherapy Acupuncture and Sports Injury Clinic	3 Bond Street Bondgate Nuneaton CV11 4DA	8am - 8pm		Private

Score card on each physiotherapy provider:

YOUR HEALTH
FIND A PHYSIO
PHYSIO2U
List your practice

CONNECT WITH US
Follow us on Twitter
Find us on Facebook
Find us on Vimeo

BASKET
View your shopping cart.

Bluebellphysio Birmingham

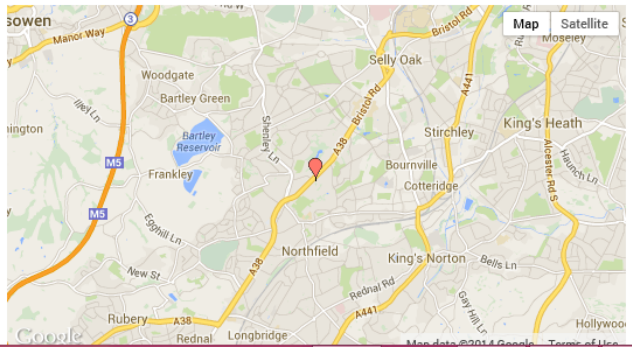
The Royal Orthopaedic Hospital
Bristol Road South
The Woodlands
Northfield
B31 2AP

View map

TELEPHONE: 01785 887 833 (Office / Clinic)

EMAIL: Contact this practice

Finding us



MORE DETAILS

SPECIALTIES: Amputee rehabilitation, Arthritis, Back, neck, joints and muscles, Home visits, Hydrotherapy / Aquatic Therapy, Learning Difficulties (Adults), Neurology inc Stroke, MS, Older people's care, Orthopaedics / Trauma, Pain management, Rheumatology, Sports physiotherapy, Women's health

PAYMENT OPTIONS:

Private

CSP MEMBERS

Nicola Pickering

Check your physio is HCPC registered

Advanced search results through Physiofirst

Show 10 entries Search:

Name	Practice name	Address
Mrs Ann McLaughlin	Ann McLaughlin Physiotherapy	1b Florence Road Ealing LONDON GREATER LONDON W5 3TU
Miss Sally Hulke	Physiotherapist	74 Dyne Road LONDON GREATER LONDON NW6 7DS
Mrs Nicola Feltham	Physiotherapy Clinic	3 Basil Street LONDON GREATER LONDON SW3 1AU
Miss Jordane Zammit Tabona	Onebody Clinic	5a Lucerne Mews Notting Hill Gate LONDON W8 4ED United Kingdom
Miss Sally Hulke	Portobello Physiotherapy Clinic	Portobello Green Fitness Club 3 to 5 Thorpe Close LONDON GREATER LONDON W10 5XL
Miss Jill Simmons	Physiotherapist	32 Clairview Road Tooting Bec LONDON GREATER LONDON SW16 6TX
Miss Sammy Margo	Sammy Margo	2a Temple Fortune House Hampstead Way LONDON GREATER LONDON N W11

Mrs Ann McLaughlin	Ann McLaughlin Physiotherapy	1b Florence Road Ealing LONDON GREATER LONDON W5 3TU

Name:	**Mrs Ann McLaughlin**
Practice Name:	**Ann McLaughlin Physiotherapy**
Address:	**1b Florence Road** **Ealing** **LONDON** **GREATER LONDON** **W5 3TU**
Work Phone:	**020 8579 2678**
Fax:	**020 8579 6780**
Work Email:	**awmclaughlin@btconnect.com**
Website:	**www.ealingphysiotherapy.co.uk**
Home Visits:	**Yes**

Areas of Practice

- Acupuncture
- Breathing and Heart Problems
- Expert Witness
- General Physiotherapy
- Hydrotherapy
- Joint Diseases (rheumatoid)
- Manipulation/Mobilisation
- Manual Therapy
- Neurology - Adult
- Orthopaedics
- Rehabilitation
- Sports Injuries

Facilities

- Gym
- Hydro Pool
- Traction

Advanced search results through revalidatie.nl

Zoek een revalidatie-instelling

U heeft gezocht op: "Plaats - amsterdam".

Toon alleen leden

Zoekresultaat: opnieuw zoeken

Onze Lieve Vrouwe Gasthuis hemelsbreed: 1.84 km

Oosterpark 9

1091 AC AMSTERDAM

T: 020-5999111

F: 020-5993378

E: informatie@olvg.nl

W: www.olvg.nl

Reade, centrum voor revalidatie en reumatologie Locatie Overtoom hemelsbreed: 2.67 km

Overtoom 283

1054 HW AMSTERDAM

T: 020 6071607

F: 020 6071890

E: info@reade.nl

W: www.reade.nl

Reade, centrum voor revalidatie en reumatologie Locatie Dr. Jan van Breemenstraat hemelsbreed: 3.32 km

Dr. Jan van Breemenstraat 2

1056 AB AMSTERDAM

T: 020 5896589

F: 020 6854921

Wachttijden revalidatiecentra

Plaats	Revalidatiecentrum	Wachttijden
Amsterdam	Reade	wachttijden >>
Apeldoorn	ViaReva	wachttijden >>
Arnhem	RMC Groot Klimmendaal	wachttijden >>
Beetsterzwaag	Revalidatie Friesland	wachttijden >>
Breda	Revant Revalidatiecentrum Breda	wachttijden >>
Den Bosch	Revalidatiecentrum Tolbrug	wachttijden >>
Den Haag	Sophia Revalidatie	wachttijden >>
Doorn	Militair Revalidatie Centrum Aardenburg	wachttijden >>
Eindhoven	Libra Revalidatie & Audiologie, Revalidatiecentrum Blixembosch	wachttijden >>
Enschede	Het Roessingh, centrum voor revalidatie	wachttijden >>
Goes	Revant Lindenhof Revant Reigerbos	wachttijden >> wachttijden >>
Haren	Centrum voor revalidatie-UMCG	wachttijden >>
Hoensbroek	Zorggroep Adelante	wachttijden >>
Huizen	Revalidatiecentrum De Trappenberg	wachttijden >>
Leiden	Rijnlands Revalidatie Centrum	wachttijden >>
Nijmegen	Revalidatiecentrum van de St. Maartenskliniek	wachttijden >>
Rotterdam	Rijndam revalidatiecentrum	wachttijden >>
Rotterdam	Capri Hartrevalidatie	wachttijden >>
Terneuzen	Revant De Wielingen	wachttijden >>
Tilburg	Libra Revalidatie & Audiologie, Revalidatiecentrum Leijpark	wachttijden >>
Utrecht	De Hoogstraat Revalidatie	wachttijden >>
Wijk aan Zee	Stichting Heliomare	wachttijden >>

Advanced search results through kiesbeter.nl

Vergelijk

Amsterdam Afstand

Kies	Naam	Adres	Afstand
☐	Bergman Clinics | Kliniek voor Uiterlijk en Huid | Amsterdam	Amsterdam, Willemsparkweg 151, 1071 GX	4.1 km
☐	Sint Lucas Andreas Ziekenhuis	Amsterdam, Jan Tooropstraat 164, 1061 AE	4.5 km
☐	DC klinieken Lairesse	Amsterdam, Valeriusplein 11, 1075 BG	4.8 km
☐	Onze Lieve Vrouwe Gasthuis, locatie Oosterpark	Amsterdam, Oosterpark 9, 1091 BC	4.8 km
☐	Onze Lieve Vrouwe Gasthuis, locatie Prinsengracht	Amsterdam, Prinsengracht 769, 1017 JZ	4.8 km
☐	Stichting Medisch Centrum Jan van Goyen	Amsterdam, Jan van Goyenkade 1, 1075 HN	4.8 km
☐	VU Medisch Centrum	Amsterdam, de Boelelaan 1117, 1081 HV	7.2 km
☐	BovenIJ Ziekenhuis	Amsterdam, Statenjachtstraat 1, 1034 CS	8.1 km
☐	Antoni van Leeuwenhoek	Amsterdam, Plesmanlaan 121, 1066 CX	11.7 km
☐	Slotervaartziekenhuis	Amsterdam, Louwesweg 6, 1066 EC	11.7 km

Kwaliteitsinformatie Academisch Medisch Centrum (AMC)

Hieronder wordt het resultaat van uw zoekopdracht getoond. Er staan alleen zorgaanbieders waarvan kwaliteitsgegevens beschikbaar zijn. Zorgaanbieders die geen kwaliteitsgegevens hebben aangeleverd, staan niet in het overzicht. Lees meer over hoe de kwaliteitsgegevens tot stand komen op Kwaliteit van zorg.

Specifieke kwaliteitsinformatie over Selecteer een aandoening

Selecteer hierboven over welke aandoening of zorgvraag u de kwaliteitsinformatie wilt zien.

Kwaliteitsinformatie algemeen

Klantervaringen 2012 — Verberg

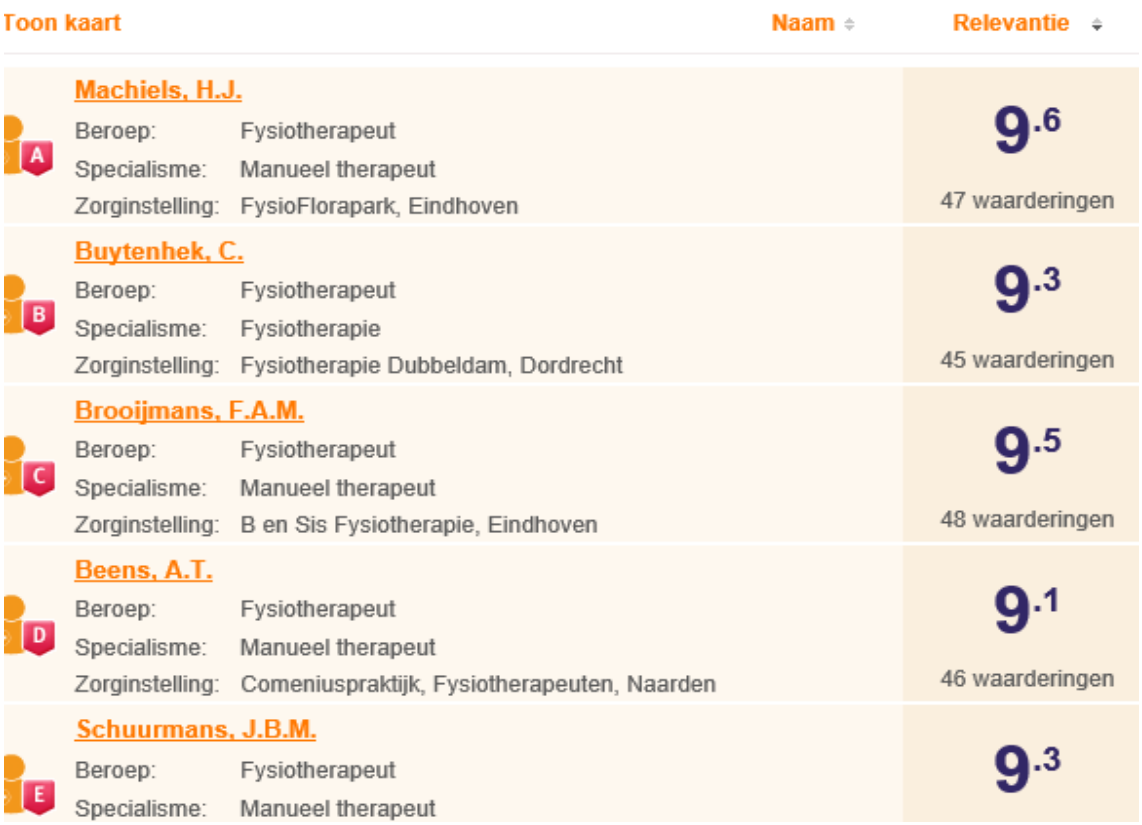
Legenda

Slechter dan gemiddeld ★☆☆
Gemiddeld ★★☆
Beter dan gemiddeld ★★★

Bereikbaarheid ziekenhuis	★★☆
Ontvangst op de afdeling	★★☆
Inhoud opnamegesprek	★★☆

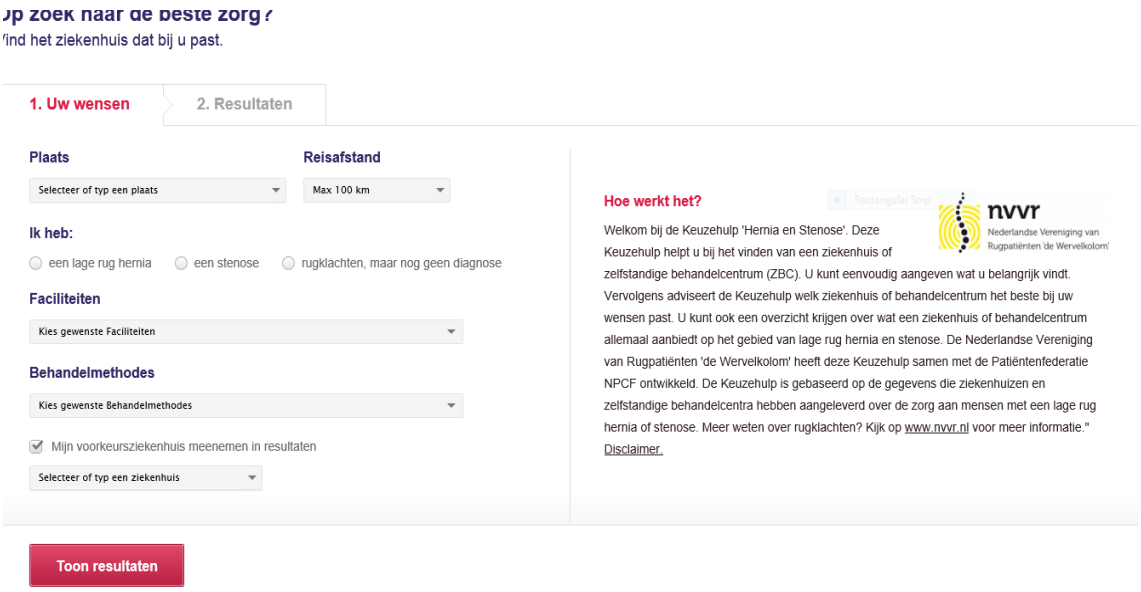
Inspectiescores IGZ 2012	Verberg ▲
Wat is het niveau van uw Intensive Care afdeling?	Niveau 3 (toegerust voor complexe patiënten)
Is het opgegeven niveau van Intensive Care bij de laatste visitatie bevestigd?	✓ ja
Hoeveel fulltime (FTE) geregistreerde intensivisten zijn er beschikbaar voor de intensive care	26,6
Bereikt u met deze bezetting een 7x24 uurs exclusieve beschikbaarheid voor de intensive care?	✓ ja
Wordt er cardiochirurgie uitgevoerd?	✓ ja
Worden er kinderen jonger dan 18 jaar beademd?	✓ ja
Is er in het ziekenhuis een team kindermishandeling actief met daarin een kinderarts en andere deskundige zorgverleners?	✓ ja
Is er in het ziekenhuis een vertrouwensarts van het Advies- en Meldpunt Kindermishandeling (AMK) aanwezig?	✓ ja
Zijn er jaargesprekken tussen het afdelingshoofd en de medisch specialist?	✓ ja
Het aantal medisch specialisten dat werkzaamheden in het ziekenhuis heeft verricht	638
Percentage medisch specialisten dat aan minimaal 1 jaargesprek heeft deelgenomen	54,7%

Advanced search results through zorgkaartnederland.nl



Provider score card

Advanced search results for specific diagnosis through zorgkaartnederland.nl



Gelre Zutphen

Locatie Zutphen

Den Elterweg 77
7207 AE Zutphen
Ga naar website

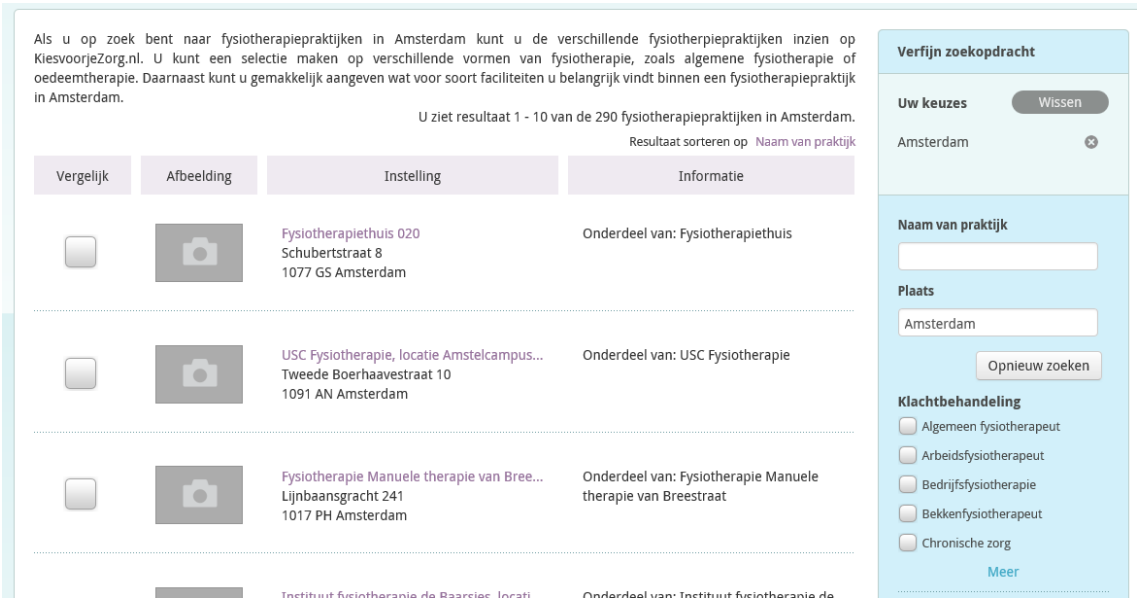
8.1

279 waarderingen bekijk alle waarderingen op ZorgKaartNederland

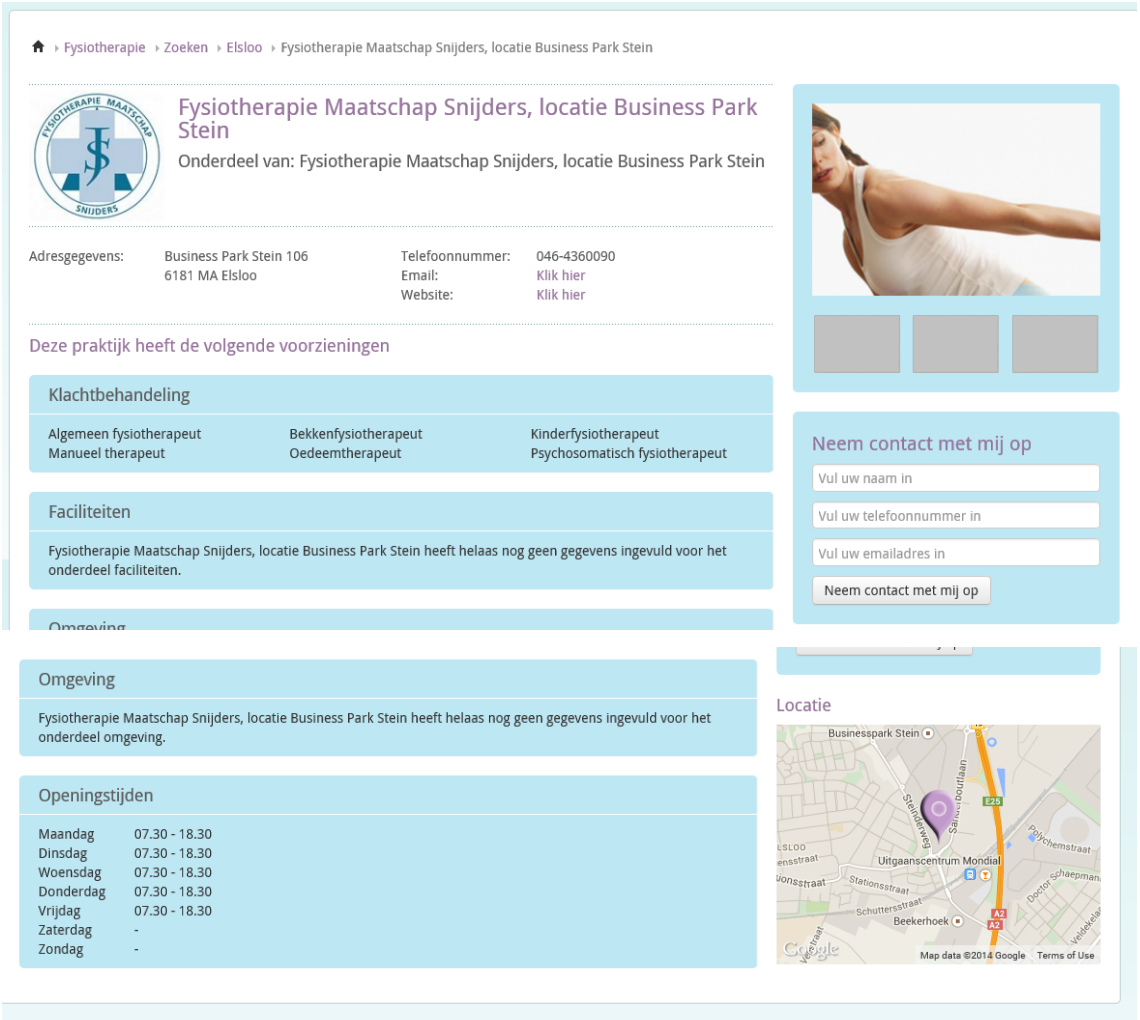
Behandelmethodes

Gewone 'open herniaoperatie'	✖
Microscopische herniaoperatie	✖
Micro endoscopische operatie via de rug	✖
Micro endoscopische operatie via zijkant lichaam	✖
Laminectomie	✖
Microchirurgische behandeling zonder verwijdering wervelboog	✖

Advanced search results through kiesvoorjezorg.nl



Provider score card



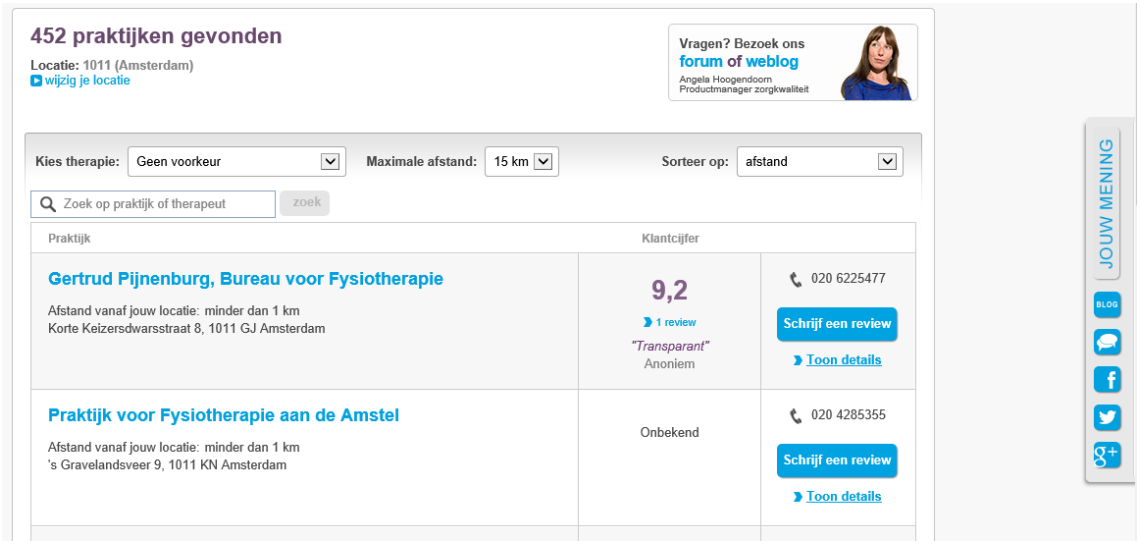
Comparing several providers through www.kiesvoorjezorg.nl

Fysiotherapie › Zoeken › Vergelijken

Fysiotherapiethuis 020	USC Fysiotherapie, locatie Amstelcam...	Fysiotherapie Manuele therapie van...
Onderdeel van: Fysiotherapiethuis	Onderdeel van: USC Fysiotherapie	Onderdeel van: Fysiotherapie Manuele therapie van Breestraat
Schubertstraat 8 1077 GS Amsterdam	Tweede Boerhaavestraat 10 1091 AN Amsterdam	Lijnbaansgracht 241 1017 PH Amsterdam
Email: FysiotherapieZuidas@gmail.com	Email: info@uscfysiotherapie.nl	Email: info@fysiotherapievanbreestraat.nl

Klachtbehandeling		Klachtbehandeling		Klachtbehandeling	
Algemeen fysiotherapeut	-	Algemeen fysiotherapeut	Ja	Algemeen fysiotherapeut	Ja
Arbeidsfysiotherapeut	-	Arbeidsfysiotherapeut	-	Arbeidsfysiotherapeut	-
Bedrijfsfysiotherapie	-	Bedrijfsfysiotherapie	-	Bedrijfsfysiotherapie	-
Bekkenfysiotherapeut	-	Bekkenfysiotherapeut	-	Bekkenfysiotherapeut	-
Chronische zorg	-	Chronische zorg	-	Chronische zorg	-
Cranofaciaal fysiotherapeut	-	Cranofaciaal fysiotherapeut	-	Cranofaciaal fysiotherapeut	-
Diëtist	-	Diëtist	-	Diëtist	-
Dry needling	-	Dry needling	-	Dry needling	-
Echografie	-	Echografie	-	Echografie	-
Ergotherapeut	Ja	Ergotherapeut	-	Ergotherapeut	-
Geriatriefysiotherapie	-	Geriatriefysiotherapie	-	Geriatriefysiotherapie	-
Handfysiotherapeut	-	Handfysiotherapeut	-	Handfysiotherapeut	-

Advanced search results through independer.nl



Score card provider

Overzicht | Reviews (1) | Behandelteam

Details

Klantcijfer	9,2 ▸ 1 review
Afstand	minder dan 1 km
HKZ Keurmerk	✖

Therapieën

	Medewerkers
Algemene fysiotherapie	1
Arbeidsfysiotherapie	0
Bekkenfysiotherapie	0
Geriatriefysiotherapie	0
Kinderfysiotherapie	0
Manuele therapie	0
Oedeemfysiotherapie	0
Orofaciaal fysiotherapie	0
Psychosomatische fysiotherapie	0
Sportfysiotherapie	0

▸ Meer over het behandelteam

100% beveelt Gertrud Pijnenburg, Bureau voor Fysiotherapie aan

Gertrud Pijnenburg, Bureau voor Fysiotherapie scoort gemiddeld een 9,2. Dit is het gemiddelde cijfer uit 1 review.

Schrijf ook een review

Zeer goed	1 review
Goed	0 reviews
Matig	0 reviews
Slecht	0 reviews
Zeer slecht	0 reviews

Totaalscore	**9,2**
Afspraak maken	Onbekend
Toegankelijkheid minder validen	Onbekend
Hygiëne	Onbekend
Klantvriendelijkheid	9,0
Tijd en aandacht	9,0
Deskundigheid	9,0
Begrijpelijke informatie	10,0
Resultaat behandeling	8,0

Laatste review

Ben jij deze fysiotherapeut en wil je reageren op een review? Dat kan!

23 januari 2011

Anoniem

Algemene fysiotherapie

"Transparant"

9,0

Spreek in een persoonlijke taal die algemeen begrepen wordt. Werkt transparant.

Vond je deze review nuttig? Ja (0) | Nee (0)

Ben jij deze fysiotherapeut en wil je reageren op een review? Dat kan!

Municipalities and municipality types among sample in pilot study.

Municipality	n	Municipality type
Helsinki	11	Urban
Espoo	2	Urban
Tampere	2	Urban
Oulu	2	Urban
Rovaniemi	2	Urban
Kouvola	2	Urban
Kirkkonummi	1	Urban
Raahe	1	Urban
Jalasjärvi	1	Rural
Hämeenlinna	1	Urban
Kemi	1	Urban
Kannonkoski	1	Rural
Kokkola	1	Urban
Nurmijärvi	1	Semi-urban
Vantaa	1	Urban
Lempäälä	1	Urban
Vihti	1	Semi-urban
Hyvinkää	1	Urban
Unknown	1	
	34	

Measures of distribution for all variables.

Kolmogorov-Smirnov test is used for interval/ratio variables, one-sample binominal test for binominal variables and chi-square for multinomial variables (Argyrous 2005).

	Test	Significance level	Distribution
Age in years	Kolmogorov-Smirnov test	.776	Normal
Age Groups 15y	One-sample Chi square	.178	Normal
Gender	One-sample binomial	.000	Abnormal
Municipality type	One-sample Chi square	.000	Abnormal
Motivational background	One-sample Chi square	.013	Abnormal
Educational level grouped	One-sample Chi square	.572	Normal
Choice importance grouped	One-sample Chi square	.000	Abnormal
Info availability grouped	One-sample Chi square	.020	Abnormal
Info source	One-sample Chi square	.000	Abnormal
Location of premises	One-sample Chi square	.001	Abnormal
Accessibility of premises	One-sample Chi square	.000	Abnormal
Opening hours	One-sample Chi square	.071	Normal
Provider's website	One-sample Chi square	.306	Normal
Pictures of premises	One-sample Chi square	.127	Normal
Language skills of provider	One-sample Chi square	.012	Abnormal
Specializations of provider	One-sample Chi square	.000	Abnormal
Work experience of provider	One-sample Chi square	.001	Abnormal
Care efficiency	One-sample Chi square	.001	Abnormal
Care effectiveness	One-sample Chi square	.001	Abnormal
Care safety	One-sample Chi square	.000	Abnormal
Reviews	One-sample Chi square	.015	Abnormal
Gender of provider	One-sample Chi square	.000	Abnormal

Measures of association. Source: G. Argyrous. Statistics for research.

Measure	Symmetry	Data consideration	Comment
Lambda	Asymmetric	At least one variable is nominal	May underestimate strength of a relationship where one variable is ordinal or interval/ratio. May equal 0 where a relationship exists.
Goodman and Kruskal Tau	Asymmetric	At least one variable is nominal	
Eta	Asymmetric	Suitable where independent variable is nominal and dependent variable is interval/ratio	Similar in logic to Pearson's *r*
Somer's *d*	Asymmetric	Both variables at least are ordinal	
Gamma	Symmetric	Both variables at least are ordinal	Not suitable for non-consistent relationship
Kendall's tau-*b*	Symmetric	Both variables at least are ordinal	Suitable only for tables with the same number of rows and columns
Kendall's tau-*c*	Symmetric	Both variables at least are ordinal	
Spearman's rho	Symmetric	Both variables at least are ordinal with many points on the scale	Special case of Pearson's *r* applied to the ranks of the scores rather than raw scores
Pearson's *r*	Symmetric	Both variables are interval/ratio with many points on the scale	Suitable for linear relationships